



1690 Stone Village Lane, Suite 501, Kennesaw, GA 30152
(706) 675-5366 ~ www.fortitudefocus.com

INSURANCE AGREEMENT
(Please read carefully, this is very important!)

As a service to you, **FORTITUDE FOCUS** will bill your insurance company for all applicable outpatient individual and/or family psychotherapy services rendered in-network. Due to the rising costs of healthcare, however, insurance benefits have become increasingly complex. Although the company handling our insurance billing is extremely thorough and spends a great deal of time ascertaining your benefits at the forefront in addition to filing your claims accurately, we still cannot guarantee that your insurance company will follow through with its original statement of benefits. In some cases, insurance companies have been known to change benefits in the middle of a policy year without notification to us as the provider. In other cases, session visit limits, co-payments, co-insurances, deductibles, or maximum allowables may vary from those originally quoted to us, thereby altering, or altogether preventing claims from paying in accordance with the benefits we as the provider have on file.

As a result, it is our policy to have a credit card on file for each client planning to use insurance. Please know that we will only charge your card as last resort, and we will never charge this card without notifying you first.

← **Please check or initial here:** I would like Fortitude Focus to collect only the percentage I am required to pay according to my insurance company for each visit (e.g., co-payment, co-insurance, deductible). As a courtesy, Fortitude Focus will then file my claim for me to receive the remainder of the payment due. Occasionally, insurance carriers elect not to pay a claim for one reason or another. In the event that this happens, I authorize Fortitude Focus to charge my credit card for the remaining balance. However, I also realize that Fortitude Focus will never charge my card for a claim without first notifying me.

Credit Card Information Required:

Name as it appears on your card: _____

Credit Card Number: _____

Exp. Date: _____ Security Code: _____

Zip code where you receive your credit card bill: _____

Client Signature: _____

Signature indicates that you agree to allow your therapist to make charges on your card without you present.

Additionally, it is our ethical obligation to be sure that you are aware of the following information regarding insurance companies. Most insurance companies require mental health practitioners to

disclose certain information about their clients in order to receive benefits. First and foremost, they always require a diagnosis. Frequently, they require additional information to justify ongoing treatment. This information may include physical health concerns you discuss during treatment, psychosocial stressors (such as problems in relationships, work, etc.), and your general level of functioning. Insurance companies often require treatment plans, and they occasionally require copies of the therapist's notes. It is our policy to protect your confidentiality by providing only the information that is absolutely necessary. All of this information will become part of the insurance company's records and is usually stored in a computer database.

Also, if your insurance policy changes, terminates, or defaults to a secondary insurance, it is your responsibility to notify me by either calling the office at (706) 675-5366 or email me at jeanette@fortitodefocus.com

We have a 24-hour cancellation policy. If you cancel an appointment with your therapist with less than 24 hours notice, you will be financially responsible for this session. Since insurance companies do not pay for missed sessions, you will need to pay for the full amount of your session rather than just your co-pay. Again, it is your responsibility to make sure that we always have the most up to date information on file regarding your insurance company as well as your most up to date contact information.

I have read the above policies, and I accept this Insurance Agreement.

Client's Name (Please Print)

Client Signature

Date