COMPASSIONATE PATHWAYS COUNSELING
Finding Your Way Through

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Third Party Payer Authorization

To be Completed by Client

Name_____ Date of Birth _____
I understand that I will be financially responsible for missed appointments, late cancellation fees, phone consultations, and any indirect services related to my case (i.e. letter writing, talking with my doctors, etc). The clinician is not permitted to conduct indirect services without my permission.

Client Signature_____ Date_____

To be Completed by Payer

Contact Person_____

Organization_____

Phone_____ Email_____

Mailing Address_____

Fee Structure: The fee for 50 minutes sessions is $85 a session. I will:
- ☐ Pay the full fee
- ☐ Pay $_____per session with client being responsible for remainder

Authorization: I authorize payment for the following serviced conducted by Mandy Schulzke, LPC:
- ☐ As many 50 minute sessions as the therapist deems necessary
- ☐ No more than _____(include total) 50 minute sessions
- ☐ Up to $_____/month for _____months
- ☐ Other: _____

By initialing each line below, I understand:

____I will not receive any clinical information about the client unless the client provides a release of information form in accordance with HIPAA regulations.

____I will receive statements on a monthly basis showing dates of service and attendance fees via mail.

____Clients with balances over $525 will be unable to schedule further appointments until balance is paid.

____This authorization may be revoked at any time in writing.

Financially Responsible Party Signature_____Date_____