



**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 \$100 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 \$600 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 _____