# Glenise Parrott, LCSW

1122 Sam Newell Road

Suite 106

Matthews NC 28105

# Financial Policy

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| PLEASE READ THE FOLLOWING CAREFULLY | | |
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| **I understand that I am responsible for my fee payment at each in person or Telehealth appointment. I understand the charge to be $175 for the initial appointment and subsequent couples sessions, and $160 each subsequent individual appointment if not covered by insurance. I understand that missed appointments or cancelled appointments where 24 hours notice was not provided will be charged the full fee. I understand that this charge is not covered by insurance and is my responsibility. I understand that I will be charged $50 should my records have to be provided to another party at my request. I understand I will be charged $50 for any letter or report that I request or require to be completed on my behalf. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.**  **Glenise Parrott, LCSW will honor contractual agreements made with those managed health care companies that stipulate specific reimbursement restrictions.** | | |
| X |  |  |
|  | CLIENT/GUARDIAN SIGNATURE | DATE |
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| **I hereby consent to treatment by Glenise Parrott, LCSW. I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to end treatment.** | | |
| X |  |  |
|  | CLIENT/GUARDIAN SIGNATURE | DATE |
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| **I hereby authorize Glenise Parrott, LCSW to file my insurance claim on my behalf for services rendered, and authorize the release of necessary medical information for insurance reimbursement purposes.** | | |
| X |  |  |
|  | CLIENT/GUARDIAN SIGNATURE | DATE |
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| **I authorize the payment of medical benefits to the provider of services.** | | |
| X |  |  |
|  | CLIENT/GUARDIAN SIGNATURE | DATE |