WINDSTONE COUNSELING
Healing with Horses

P.O. Box 5
Springville, UT 84663
(385) 325-0533
www.windstonecounseling.com

Financial Agreement

Client Information

Name: _____ Date of birth: ____/____/____ Age: _____

Home phone #: _____ Cell #: _____

Address: _____

City: _____ State: _____ Zip: _____

Private Pay

☐ HSA ☐ Flex ☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Name on Card:_____

Card Number: _____

Expiration Date: _____ Security Code: _____

Insurance

Policy holder's name: _____ Date of birth: ____/____/____

Relationship to the patient: ☐ Spouse ☐ Parent ☐ Other: _____

Insurance Company: _____ Health plan: _____

Policy #: _____ Group #: _____ FECA #: _____

Phone Number:_____ Effective date: ____/____/____

Address to send claims: _____

Any other information on the card? _____

Third Party Billing

Payments for EAP services will be made by _____ (name) who is my _____ (relationship). By signing below, they have agreed to pay the clinician's fee of $_____ for the intake assessment, and $_____ per session for _____ (number) sessions, beginning _____ (date). Sessions will be held weekly, biweekly, monthly (circle one).

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If applicable to third party billing:

_____ ____/____/____
Printed Name of Benefactor Date

_____
Signature of Benefactor

I agree to receive Equine-Assisted Psychotherapy (EAP) services from Windstone Counseling, LLC, and agree to make full payment at the time services are rendered as outlined in the Practice Policies. I agree to the cancellation policy which outlines that I (not insurance) will be billed for the full price of the session if I do not cancel or reschedule 24 hours prior to the scheduled session. I will provide credit card information which will be billed for missed appointments and/or accounts that are 60 days delinquent. I understand that if payment is not received by a third party benefactor within 60 days of each session, I will am responsible for payment.

_____ ____/____/____
Printed Name of Client Date

_____
Signature of Client

☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Name on Card: _____

Card Number: _____

Expiration Date: _____ Security Code: _____

I, the clinician, have discussed the issues above financial agreement with my client (and/or the person legally acting on behalf of the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent and able to give informed and willing consent.

_____ ____/____/____
Printed Name of Therapist Date

_____
Signature of Therapist