Rachel Yost, LPCC-S, LICDC
counseling@rachel-yost.com

BILLING AND FINANCIAL AUTHORIZATION

This document explains how your health information may be used to bill third parties when applicable, your financial responsibility, and our cancellation/no-show policy.

AUTHORIZATION TO BILL INSURANCE / EAP (IF APPLICABLE)

I authorize Rachel Yost, LPCC-S, LICDC to disclose the minimum necessary protected health information required for billing purposes to my health insurance company and/or Employee Assistance Program (EAP), if applicable. This may include diagnosis codes, treatment dates, and services provided, solely for the purpose of determining coverage, eligibility, payment, or reimbursement for services.

I understand that:

- My insurance company or EAP may require access to this information in order to process claims.
- I am responsible for understanding my insurance/EAP benefits, including deductibles, copayments, and coverage limitations.
- If my insurance or EAP denies any or all of payment for any reason, I understand that I am responsible for the full cost of services rendered.

CANCELLATION AND NO-SHOW POLICY

I understand that scheduling an appointment means that time is reserved specifically for me. I agree to provide at least **24 hours' notice in writing** (email or approved client communication method) if I need to cancel or reschedule an appointment.

I understand that:

- Appointments canceled with less than 24 hours' notice will be deemed missed appointments (or "no-shows").
- Failure to attend a scheduled session may result in a cancellation fee of $100 being charged to my card on file.
- Insurance and EAP plans typically do not reimburse cancellation fees, and I am personally responsible for these charges.

RELEASE OF INFORMATION FOR BILLING PURPOSES

I authorize the release of information necessary for billing, payment, and claims processing purposes to insurance companies, EAP administrators, or designated billing services. This authorization is limited to information necessary for payment and does not extend to general treatment disclosures outside of billing purposes.

CREDIT OR DEBIT CARD AUTHORIZATION

To simplify billing and ensure timely payment for services, I understand that I am required to maintain a valid credit or debit card on file with Rachel Yost, LPCC-S, LICDC, for the duration of treatment.

I authorize Rachel Yost, LPCC-S, LICDC, to securely store my payment information and charge my card for amounts I am financially responsible for, including but not limited to:

- Copayments, coinsurance, and deductibles.
- Any balance remaining after insurance or Employee Assistance Program (EAP) processing.
- Self-pay session fees.
- Fees for late cancellations or missed appointments in accordance with practice policy.

Whenever possible, insurance claims will be submitted prior to charging my card. If my insurance carrier adjusts or reprocesses a claim after payment has been collected, any resulting credit or balance due will be applied or refunded as appropriate.

I agree to provide updated payment information promptly if my card expires, is replaced, or otherwise becomes invalid. Failure to maintain a valid payment method on file may result in suspension or delay of non-emergency services until updated payment information is received.

I understand that my payment information will be stored and processed using a secure, HIPAA-compliant payment processor. My complete card number will not be accessible to the practice after it has been securely stored.

By signing below, I authorize Rachel Yost, LPCC-S, LICDC, to charge my card in accordance with this agreement until I revoke this authorization in writing or my treatment relationship ends. I understand that revoking this authorization does not relieve me of responsibility for any outstanding balances owed.

I, _____ (print name) authorize Rachel Yost, LPCC-S, LICDC to charge my credit or debit card below for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Card Type: ▢ MasterCard ▢ VISA ▢ Discover ▢ AMEX ▢ Other: _____

Cardholder Name (as shown on card): _____

Card Number: _____ Expiration: _____

CVC: _____ Zip Code (from card billing address): _____

Client Signature: _____ Date: _____

I certify that I have received this Billing and Financial Authorization form for Rachel Yost, LPCC-S, LICDC. I understand and agree to the terms outlined above.

Client Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Client Full Name: _____

PLEASE RETURN COMPLETED FORM VIA EMAIL TO counseling@rachel-yost.com