OFFICE COPY

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

You will be financially responsible for any fees that are not covered by your insurance plan. These often include, but are not limited to:

1) Have not met deductible
2) Copayments or coinsurance
3) Provider is not in-network
4) You are not current with your insurance premiums
5) Number of sessions exceeds approved sessions
6) Pre-authorization required and not obtained
7) Service not covered or denied by insurance
8) Failure to give adequate notification by **12:00PM PST one business day in advance** of scheduled appointment for cancellations or rescheduling appointments

---

I understand the above and will be financially responsible for services rendered but not covered by my insurance plan.

I understand that charges for any of the abovementioned reasons will be billed automatically to my card and will not be disputed.

I understand that Logical Behavioral Health requires a credit card on file to commence services.

Card Type: ☐Visa ☐MasterCard ☐American Express ☐Discover

Credit Card Number:____

Expiration Date:________________________ CVV:______________

______________________________ ____________
Name as it appears on card Billing Zip Code

______________________________ ____________
Patient/Financial Guarantor’s Signature Date

Please sign below to bill this credit card for regularly scheduled appointments:

______________________________ ____________
Patient/Financial Guarantor’s Signature Date