GUIDING PATHS
COUNSELING

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Financial Responsibility Agreement

I, _____, understand that it is my responsibility to provide my provider with current, up-to-date, and active insurance information. I agree to be financially responsible for any unpaid balances from claim denials due to, but not limited to:

- Providing inaccurate insurance/policy information to my provider
- Not providing updated insurance information within 30 days of any insurance/policy change
- Not informing my provider of having secondary insurance by the first session
- Not informing my provider about any secondary insurance changes within 30 days of those changes

By signing below, I hereby acknowledge my responsibility to inform my provider, in writing, of any changes in my insurance within 30 days of those changes. I also agree that if I fail to provide this information, in writing, within 30 days, my provider may terminate treatment services and provide referrals to alternative providers. I also understand that if any unpaid balance exceeds 90 days, it will be forwarded to a debt collection agency.

_____ _____
Client or Guardian Name (Print) Date

_____ _____
Client or Guardian Signature Date

_____ _____
Clinician's Signature Date