

THIRD PARTY PAYMENT AUTHORIZATION

I/We affirm that North Star Counseling (NSC) is authorized to bill

_____ (Responsible Entity), represented by

_____ (Agent), for counseling services rendered to

_____ (Clients) by NSC, less a client co-pay amount of

\$ _____ per session or _____ % per session. Any client pay amount will be paid at each session by check, cash or debit/credit card.

I/We understand that the Responsible Entity will be billed and is responsible for all charges for aforesaid services rendered to the Client. No-show fees (or cancellations less than 24 hours in advance) will be billed at \$30 and will be paid by _____. The Client(s) gives permission to NSC to bill the Responsible Entity at the address below, and contact them by phone if needed. I/We understand that any change in this relationship necessitates advance notice of 15 days in writing or verbal authorization by Responsible Entity.

Entity Name: _____

Entity Agent/Representative: _____

Billing Address: _____

Billing Phone Number: _____ or _____

Client Date

Responsible Entity/Party Date

Representative Date

Therapist Date