Learning Consultants
9890 Clayton Road • Ladue , MO 63124
Office 314.222.5886 • Fax 314.222.5887

Financial Responsibility Form

Date _____ Client Name _____

Address _____
Street City State Zip

Phone _____ Birthdate _____

In consideration of services to the client designated herein at my (our) request, I (we) guarantee agree to pay the charges of Learning Consultants, Inc. at time of service, including any amount not paid by my insurance plan.

By signing this financial responsibility statement the client and guarantor(s) acknowledge and agree they are responsible for payment of Learning Consultants' billed charges in any case in which payment is denied by the health insurance organization.

I (we) hereby authorize my (our) insurance benefits to be paid directly to Learning Consultants, Inc. I (we) understand that I (we) am/are financially responsible for non-covered services, as well as any deductibles, coinsurance or amounts in excess of insurance benefits.

We at Learning Consultants realize that problems arise and that appointment changes are sometimes required. Please call no later than 24 hours prior to your scheduled time to cancel or change an appointment. This way we are able to schedule other individuals who desire an appointment, and with a cancellation notice you will not be charged for a missed appointment.

_____
Client and (or) Guarantor Signature Date

_____ Please (check here) keep my credit card on file and run through monthly for group sessions attended.

_____
Signature

_____
Credit Card #

_____
Exp. Date CV Code (on back)