Financial Responsibility Form

Learning Coach LLC - Bellingham, WA - LearningCoachWA.com - 360-207-4560

Financial Responsibility Statement. Learning Coach LLC strives to make services accessible to clients by utilizing third-party payer sources that reduce the financial cost to the client. However, all services require a designated person to assume financial responsibility for services not covered by insurance.

Good Faith Estimate. Learning Coach LLC services are estimated at the cost of $200 for evaluations and $120 per treatment session. One session per week would then cost $1,520 per service quarter ($560 in the first month and $480 for each of the following 2 months). Two sessions per week would then cost $3,040 per service quarter ($1,120 in the first month and $960 for each of the following 2 months).

Third-Party Payer Sources. Learning Coach LLC offers an estimate of benefits to clients who provide the Insurance Verification Form, and offers a statement of insurance reimbursement ("superbill") at the end of every service month for those opting to use a third-party payer source. Learning Coach LLC is committed to furnishing complete and accurate records of medically necessary services for third-party payer sources, but does not become involved in disputes between clients and third-party payer sources regarding uncovered charges or reasons for denial. Learning Coach LLC will provide if a third-party payer source determines that a rendered service is not covered.

Payments Due. Payment is due at the time of service, or upon notification that a third-party payer source has not covered services. If fees are not paid in full, services may be postponed or canceled until payment is received.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client name_____Date of Birth_____

Financially responsible
party's name:_____Relationship to client_____

Signature_____ Date_____

continue to Insurance Verification Form →

Insurance Verification Form

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To receive an estimate of benefits coverage, please submit the following information:

Insurance Company Information:

(This information should all be found on your insurance card).

Insurance Company Name:_____

Insurance Company Phone Number:_____

Insurance Company Address:_____

Policy Information:

Name of Insurance Plan Holder_____

Relationship to student / client / patient:_____

Policy Number:_____

Group Number_____

Optional, Helpful Information:

Medical Deductible_____

Medical Out-Of-Pocket Max_____

BY SIGNING BELOW I AM AGREEING THAT I HAVE PROVIDED THE MOST ACCURATE AND UP-TO-DATE INFORMATION AVAILABLE TO ME.

Financially responsible party's name:_____

Signature_____ Date_____