

**JESSIE L. DIAMOND, M.Ed, LPC, NCC**

2325 E. Burnside Street  
Portland, OR 97214-1655

Financial Policy and Fee Agreement

**Fees:** Insurance reimbursed appointments are charged at the rate of \$120.00 per fifty-five minute hour and \$60.00 per 25-minute half hour. Telephone calls longer than five minutes will be billed at the hourly rate. Private pay appointments are charged at the rate of \$80.00 for individuals, \$100 for couples, and \$120 for families.

**Payment:** Services are to be paid for in full with cash or check unless Jessie Diamond, LPC is a contracted or in-network provider under your insurance policy, in which case your co-pay or co-insurance will be due. Please have your payment available at the beginning of each visit to allow you to leave with session content in mind rather than business matters.

**Cancellations/Missed Appointments:** It is important that you keep your scheduled appointments. Appointments not cancelled 12 hours in advance will be billed to you at the full rate. Insurance does not cover these charges.

**Health Insurance:** Your visits may be covered by your health insurance policy. Your health insurance will be billed for you as a courtesy if that works best for you. Reimbursement policies differ dramatically from one insurance company to another. You are responsible for knowing the details of your insurance coverage. You are responsible for obtaining authorizations as required by your health plan. If you have questions regarding your coverage, it is recommended that you contact your insurer directly. If Jessie Diamond, LPC is a contracted or in-network provider under your insurance policy, then the policies and procedures of your Managed Care Plan will govern fees and payment of fees for professional services.

**If Jessie Diamond is not an in-network provider, you may be billed for any difference between the amount of her fee and the amount of insurance reimbursement.**

**NSF/Returned Checks:** NSF/Returned checks will be subject to a \$35.00 service fee.

Re-billing: Patient balances left unpaid over 90 days will be charged a 1.5% (minimum \$5.00) fee per month.

**Collections:** Your account may be turned over to a third-party collection agency if we are unable to collect from you directly. The collection agency may be notified of the nature of the services provided. You will be responsible for all costs, including attorney fees and court fees, associated with the collection of monies due.

**I have read and understand the above stated information. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Jessie Diamond, LPC. I understand the financial policy established by Jessie Diamond, LPC.**

Agreed-upon fee/co-pay: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Name: (Please print): \_\_\_\_\_

**JESSIE L. DIAMOND, LPC, NCC**  
Billing Information and Benefit Verification Form

**Patient Information (Please print clearly)**

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_  
Marital Status: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Private/personal Email: \_\_\_\_\_  
May messages be left for you at: Home? \_\_\_\_\_ Cell? \_\_\_\_\_ Email? \_\_\_\_\_

**Insurance Information** – Please provide a copy of your insurance card(s), front and back, or bring your card(s) to your first appointment so that copies can be made.

**Primary Insurance Carrier:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Relation to Client: \_\_\_\_\_  
Insured ID number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Insured D.O.B.: \_\_\_\_\_ Phone: \_\_\_\_\_ Employer: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

**Secondary Insurance Carrier:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Claims Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ Relation to Client: \_\_\_\_\_  
Insured ID number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Insured D.O.B.: \_\_\_\_\_ Phone: \_\_\_\_\_ Employer: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

I hereby authorize the release of all medical information necessary to process an insurance claim. I hereby authorize my insurance company to make payments directly to Jessie Diamond, LPC. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Jessie Diamond, LPC. I understand the financial policy established by Jessie Diamond, LPC. I understand that balances left unpaid over 90 days from the date of service may be assessed a 1.5% re-billing/past due account fee (minimum \$5.00) per month and and/or may be referred to a collection agency to facilitate payment.

**Name (please print):** \_\_\_\_\_  
**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*\*\*\*

**For office use only:**

Outpatient mental health benefits for this provider? \_\_\_\_\_ In network? \_\_\_\_\_  
Authorization needed? \_\_\_\_\_ Obtained? \_\_\_\_\_ Auth #: \_\_\_\_\_  
# of visits authorized: \_\_\_\_\_ Start Date: \_\_\_\_\_ Exp Date: \_\_\_\_\_  
Deductible: \_\_\_\_\_ Met: \_\_\_\_\_ Co-pay/Co-ins: \_\_\_\_\_  
Benefits Limits: \_\_\_\_\_  
How much used? \_\_\_\_\_  
Notes:

Verified by: \_\_\_\_\_ Date: \_\_\_\_\_

