William Douglas McFarland LCSW
6304 Roseborough Drive
Austin, Texas 78747
512/705-1462 cell/office

Treatment and Financial Contract/Consent

I, _____ consent for William Douglas McFarland LCSW to bill my insurance company for services rendered. I assign all insurance benefits directly to William Douglas McFarland LCSW otherwise payable to me for services rendered. I hereby authorize William Douglas McFarland LCSW to release all information necessary to secure the payment of benefits.

I understand that it is my responsibility to determine if there is a deductible that remains to be paid.

Insurance co-payments are due at the time that services are rendered.

I understand that William Douglas McFarland LCSW may not be on my insurance provider panel. If insurance assignment is not accepted, I understand that I will be billed at the rate of $130.^{00}$ per hour for services rendered (or in some mutually agreed upon circumstances a sliding scale fee of $ _____.^{00}$).

I understand that a scheduled appointment means that time is reserved for me. If an appointment is missed or cancelled with less than 24 hours' notice, I will be billed according to the scheduled fee ($45.^{00}$). I understand that 3 missed appointments without sufficient cancellation notice may result in the termination of treatment.

I agree to a one-time charge on my credit card for any late cancellation fee or unanticipated insurance deductible (not to exceed $130.^{00}$) affecting reimbursement. Type of credit card _____. Credit card number _____. Security code _____. Expiration date _____.

I understand that William Douglas McFarland LCSW employs the billing services of OfficeAlly™ and I consent to the release of pertinent information to this service for the support and operation of this practice. Pertinent information is limited to name, demographics, DSM V codes, CPT Codes, insurance carrier, dates of service, copayments, and insurance payments.

If I am asked to submit to an assessment from a psychiatrist, I will comply if it is within my resources to do so.

I understand that if I have any complaints with my insurance company I may contact the Texas Department of Insurance, Consumer Protection, MC 111-1A, PO Box 149091, Austin, Texas 78714-9091, Consumer Help Line 800-252-3439, Fax: 512-490-1021. I may also submit a complaint on-line at www.apps.tdi.state.tx.inter/perlroot/consumer/complform/complform.html.

I understand that this is a legally binding contract and that any changes, additions, or subtractions will be agreed upon by both parties in writing.

_____ _____

Signature of client/parent/guardian Date

_____ _____

William Douglas McFarland LCSW Date