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Financial Responsibility and Guarantee of Payment for Services

Thank you for choosing D J Koehn Consulting Services Inc. to work with you and/or your family. By signing this form, you agree to be charged for direct and indirect services that we provide. Direct services include but are not limited to: face to face counseling, assessment/evaluation, consultation, and observation. Indirect services include but are not limited to: attend IEP meeting, advocacy, report writing, and phone calls over 10 minutes. The standard hourly (50-minute) rate is \$180. Assessment/Evaluation services involve billing for actual hours spent testing and time spent scoring, interpreting, and writing up results. Comprehensive reports generally require 2 to 5 hours and insurance companies rarely pay for this service.

Appointments are specifically held for the client and it is important that you give us 24 hour notice if you intend to cancel. If we do not receive notification within that time frame then we cannot fill that time slot with another client; therefore, we will charge you up to but no more than to our standard hourly rate (\$180/hr.) for the late cancellation.

For returned checks, you are expected to pay the bank fee and the full charge for those services in cash. By signing this form, you are also consenting to allow D J Koehn Consulting Services Inc. to contact your insurance company regarding payment of services. It is your responsibility to understand your insurance plan. Any precertification which is required by your insurance company must be done prior to your appointment. This must be submitted to D J Koehn Consulting Services Inc. before services are rendered. It is difficult to understand all of the caveats of each insurance company and you will be responsible for payments which are not covered by your insurance company. Any issues with reimbursement are the responsibility of the client and the insurance company, not D J Koehn Consulting Services Inc.

If you would like to have a credit card on file, please provide the credit card information below.

AMERICAN EXPRESS VISA MASTERCARD DISCOVER

Full name on card _____ Expiration Date _____

Credit Card # _____ Security Code _____

Credit Card Billing Zip Code _____

By signing below, you authorize D J Koehn Consulting Services Inc. to charge your card for any unpaid balance after insurance discounts. If your carrier does not pay within 30 days and you are notified by phone/email, you will be given an additional 10 days to settle the balance. If not, your card will be charged for the unpaid balance.

Name of client

Date

Signature of adult client or parent/guardian of client