Alyssa Hagmann, M.A., LMFT

4041 Ruston Way Suite 202 Tacoma, WA 98402 | 253-254-6681

Financial/ Insurance Agreement

Client Name_____ Birthdate_____

☐ Fee without Insurance..... _____

☐ Insurance co-pay....._____ (please complete insurance information)

Insurance Information

Insurance Company_____ Phone #_____

ID Number on Card_____ Group Number_____

Name of Primary Insured_____ Birthdate_____

Address of Insured_____

Phone # of Insured_____Employer_____

Client relationship to Insured: ☐ Self ☐ Spouse/Partner ☐ Child ☐ Other_____

Client/Responsible Party Financial Agreement Statement

- All payments are due at the time of service (including co-pays and fees).
- I understand that I am responsible for paying my deductible and any amount not covered by insurance.
- Appointments cancelled with less than 24hr notice will be charged the full fee. Insurance and third-party payers do not cover late-cancellation or no-show charges.
- I understand that if, for any reason, payment is denied by my insurance company, I will be responsible for the full amount.

I authorize the release of any records or information necessary to process insurance claims to Alyssa Hagmann, M.A., LMFT.

_____ Date_____

Client or Responsible Party