

**The Attachment and Trauma Center of Nebraska**

**Financial Responsibility and Assignment of Benefits**

I understand that I am responsible for the expense of all mental health care services provided to me by The Attachment and Trauma Center of Nebraska (ATCN).

I hereby assign to ATCN any insurance or other third-party benefits available for mental health care services provided to me. If these benefits are not assigned to ATCN, I agree to forward immediately upon receipt, all health insurance and other third-party payments I receive to ATCN for services rendered to me.

I instruct and direct \_\_\_\_\_ insurance company,  
policy # \_\_\_\_\_ and group # \_\_\_\_\_ to  
pay by check, made out and mailed directly to The Attachment and Trauma Center of Nebraska.

I further agree that should the insurance be insufficient to cover the entire expense or does not cover the expense once the Explanation of Benefits is received, that I am responsible for payment of services. Billing for unpaid charges and filing dates for insurance claims are sent monthly. My prompt payment of unpaid balances is expected monthly.

Name of Client \_\_\_\_\_

Signature of Client \_\_\_\_\_

Signature of Parent/Legal Guardian \_\_\_\_\_

Signature of Witness \_\_\_\_\_

Date \_\_\_\_\_

**Cancellation Policy**

Please be advised that any appointments made with a therapist must be cancelled with a minimum of 24 hours notice. If you do not attend your appointment and you have not cancelled at least 24 hours in advance, you will be charged a cancellation fee up to the full amount of your usual payment. This cancellation fee will not be covered by insurance and will be due and payable before your next appointment.

This policy applies to individual, family and group therapy sessions.

\_\_\_\_\_  
I, the above signed, understand and agree to abide by this policy

\_\_\_\_\_  
Date