CLIENT FINANCIAL AGREEMENT

Client Name		**Client Email**	
		Client Cell	
Parent/Guardian Name		**Parent Email**	
		Parent Cell	
Payment Method	Time of Service Advance Self-Pay Monthly Self-Pay Insurance /co-pay		
Insurance Details	Insurance Company:		
	Primary Policy Holder		
	Group Number		
	Client Policy Number		

DIRECT DEPOSIT / ELECTRONIC FUND TRANSFER: When making an online or direct deposit please ensure the CLIENT name is noted in the narration/memo so that the deposit can be accurately applied to account.

Bank: Cayman National **Branch**: Elgin Avenue
Name: The Wellness Centre **Type**: KYD Chequing
Account#: 011-09070

CREDIT CARD AUTHORIZATION: To have The Wellness Centre charge a credit/debit card for service fees complete the information below and return by hand directly to the Billing Administrator.

Client Name			
Cardholder Name			
Card Number			
Expiry Date		**CCV**	
Card Type	☐ Visa ☐ Mastercard	**Currency**	☐ KYD ☐ USD

AUTHORIZATION: I hereby authorize The Wellness Centre Ltd to charge the credit/debit card listed above for the following: **select one**

- ☐ SELF-PAY | Fees for services on date of appointment (courtesy discount applied)
- ☐ SELF–PAY | Invoiced Monthly fees
- ☐ Insurance Co-Pay charged on date of service, insurance claim to be submitted by The Wellness Centre.
- ☐ SELF-PAY | PAYMENT PLAN: Overdue balance as of _____ day of _____, 20___ is KYD$_____. _____ payments of KYD$_____ will be applied on the 1st day of each month ending _____ day of _____, 20___.

FINANCIAL RESPONSIBILITY

- ☐ I accept full responsibility for all costs associated with services outlined herein received from The Wellness Centre.
- ☐ If paying by **credit card**; I accept the responsibility to update The Wellness Centre if card details change.

- ☐ If paying by **direct bank transfer**; I accept responsibility to ensure transactions are made accurately and in a timely manner to ensure deadlines of receipt of funds.
- ☐ With acceptance of **insurance coverage**, I understand The Wellness Centre may verify my coverage as a courtesy; but The Wellness Centre cannot be held responsible or liable for inaccurate information provided by my insurance provider.
  - ☐ I accept responsibility to confirm coverage with my insurance provider and communicate to The Wellness Centre any changes in my insurance coverage or policy immediately so that claims can be filed within the insurance providers deadlines. I accept responsibility for the full fee for services rendered but not covered by my insurance carrier.
  - ☐ I understand co-pays, coinsurance, deductibles, and any services not covered by my insurance plan must be paid at time of service.
  - ☐ I am responsible for obtaining and providing any required medical referrals. It is my responsibility to meet the referral requirements of my insurance provider.
  - ☐ Should my referral expire and service(s) are provided during any period when a referral is not active, I am responsible for payment.
  - ☐ Insurance companies will not pay for missed appointment fees or late cancellation fees, I accept responsibility for these fees.
  - ☐ I am responsible for the balance of any insurance claims not paid within 30 days.

NAME FINANCIALLY RESPONSIBLE PERSON_____

SIGNATURE: _____

Dated the _____ day of _____, 20_____.