Client Financial Responsibility Agreement

The following document explains The Wellness Centre's payment policy and financial responsibility for all clients (including minors). It aims to minimize any misunderstanding about payment for services.

Client Name		**Client Email**	
		Client Cell	
Parent/Guardian Name (if Under18)		**Parent Email**	
		Parent Cell	
Payment Method	☐ Self-Pay ☐ Health Insurance ☐ Corporate Wellness Benefit		
Insurance Details	Insurance Company:		
	Primary Policy Holder		
	Group Number		
	Client Policy Number		

FINANCIAL RESPONSIBILITY

- I accept full responsibility for all costs associated with the services I receive from The Wellness Centre.
- I accept that I may utilize my health insurance coverage and that The Wellness Centre may verify my coverage as a courtesy however, The Wellness Centre cannot be held responsible or liable for inaccurate information provided by myself or 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 provider's deadlines.
- I accept responsibility for the full fee(s) for services rendered but not covered by my insurance provider.
- I accept that any co-pay, coinsurance, deductible, and / or service not covered by my insurance plan must be paid at time of service.
- I accept that The Wellness Centre and / or therapist(s) may release any information as necessary to process claims to my health insurance company.
- I accept that I am responsible for obtaining and providing any required medical referrals. It is my responsibility to meet the referral requirements of my insurance provider.
- I accept full responsibility for the payment due on services that are provided during any period when a referral is not active and / or expired.
- I accept full responsibility for the fees associated with missed appointments and / or late cancellations. (**The full-service fee will be charged for no show appointments, and a partial payment will be charged for appointments cancelled with late notice less than 24hrs)**.
- I accept that no Corporate Wellness Contract or health insurance plan can be utilized to cover the fees associated with missed or late cancellations.
- I accept full financial responsibility for any additional services such as phone calls, letter writing, completion of forms, and administrative meetings in or out of the office. These services will be billed at the usual rate and will remain the client's obligation to pay.
- I accept the responsibility to immediately update The Wellness Centre of any changes to the credit / debit card associated with my payments.
- I accept the responsibility to immediately update The Wellness Centre of any changes of physical / billing address and contact information.

- I accept the responsibility to ensure that any **direct bank transfers** are made accurately and in a timely manner, to ensure The Wellness Centre is in receipt of funds on their respected due date.
- I accept that The Wellness Centre reserves the right to charge interest and/or pursue delinquent accounts via third party collection agencies or attorneys at the client's cost.
- I accept that I am expressly waiving privileges concerning disclosure of all information necessary to proceed with collection activities and acknowledge an itemized account history, showing services rendered, fees charged, and payments received may be filed as an exhibit.
- I accept that this Financial Responsibility Agreement is valid for all sessions and/or services rendered by The Wellness Centre. A copy of which may be used in place of the original agreement signed.

All invoices / receipts are presented in **Cayman Islands Dollars** and payments by USD cash, credit / debit cards, and wire transfers are accepted at the exchange rate of 0.80. **Services may be suspended if your account is more than 30 days in arrears.**

PAYMENT DETAILS

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 Bank | **Branch**: Elgin Avenue
Account Name: The Wellness Centre Ltd.
Account Type: KYD Chequing
Account Number: 011-09070

CREDIT CARD AUTHORIZATION: I authorize The Wellness Centre to charge a credit/debit card for service fees delivered.

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

I have read, understand, and my signature below indicates my agreement with the above policies.

Print Name	
Signature	
Date	