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FINANCIAL POLICY AND FEE AGREEMENT

Our office will verify your insurance benefits as a courtesy to you.

Our office makes sure that your insurance is billed in a timely manner, and that the benefits your insurance company affords you, are the same benefits quoted to us when we verified your benefits.

In this regard, you are liable for all amounts your insurance deems are your responsibility. These are normally:

- Deductible amounts
- Co-Insurance (percentage) and/or Co-Pay amounts (flat amount)
- Non-covered services
- Services rendered before insurance policy began or after it was terminated
- Fees for sessions canceled less than 24 hours in advance

We will need to charge you $75 for any session canceled with less than 24 hours notice if the reason is not an emergency, or for any missed session. I also charge a fee for emergency or other calls after hours. If this becomes necessary, I would discuss this with you first and come to an agreement on payment - before taking such action.

It is preferred that you pay your expected responsibility amounts by check at the time of service. However, as a courtesy to you, our billing manager may instead put amounts deemed to be your responsibility on your Debit, Credit, or HSA/HRA card, once your insurance has processed your claim correctly, or earlier if deemed appropriate by the billing manager.

PLEASE PROVIDE US WITH A CREDIT, DEBIT, OR HSA CARD:

By signing below, you are authorizing our office to run the above stated valid amounts on the following Debit/HRA/Credit Car as per our agreement on page two:

Card Number: _____

Card Expiration Date: _____

3 Digit CVV (on the back of the card): _____

Name on the card: _____

Full Address of Credit Card holder (must match credit card company's records):

_____ City _____ State ____ Zip _____

Email address to send receipt: _____

Client Signature _____

Date _____

This authorization remains valid for all amounts for which client is responsible, including all sessions and services received by client.

FEE AGREEMENT -- TO BE COMPLETED BY THERAPIST AND CLIENT TOGETHER:

My full fee is $125.

We agree that you will be charged $_____/ session, and that you will:

_____ pay $_____ at each session:
_____ pay your fee in full within thirty days of receiving a statement;
_____ collect from your health benefit plan and be responsible for paying me at time of service;
_____ I will submit and collect form your health benefit plan and you will pay your copay as applicable.

Client Preferred Payment Method: Cash Check Credit Card

I have read and discussed the preceding two pages of information and understand my rights and financial responsibilities as a client.

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date