

Financial Agreement

By signing below, I agree to pay all amounts owed. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me.  However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owed. All co pays, coinsurance, deductibles and any outstanding balances are due at the time of service. The following is included in this policy:

1. I understand that I will be will be expected to pay at the time of service. Cash pay rates are set at $150.00 for intakes, $135.00 for family/couples therapy, and $120.00 for individual therapy. No clients will be permitted to maintain outstanding balances on accounts. If payments are not resolved, services may be temporarily postponed until arrangements are made.
2. I understand that I will be charged a LATE CANCELLATION fee of $25.00 if I fail to give at least 24-hour notice prior to cancelling my appointment. Exceptions will be made on a case by case basis for emergency situations, sickness, or other circumstances. This fee will not be covered by insurance and is an out-of-pocket expense.
3. I understand that I will be charged a NO-SHOW fee of $50.00 if I fail to attend my appointment. Exceptions will be made on a case by case basis for emergency situations, sickness, or other circumstances. This fee will not be covered by insurance and is an out-of-pocket expense.
4. I understand that there will be a bounced check fee of $25.00. This fee will not be covered by insurance and is an out-of-pocket expense.
5. I understand that I am responsible for knowing my co-payment amount and deductible amount. It is important to note that insurance coverage depends solely on your insurance provider and your individual plan.
6. I understand that the therapy session will last 45 to 55 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time.

By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

Client Name (Please Print)

Client/Guardian Signature Date

Therapist Signature Date