CLIENT FINANCIAL INFORMATION AND FEE AGREEMENT

NAME: ___________________________________ DATE:____________________
D.O.B.: ___________________________________

ADDRESS:____

PHONE:(M)__________________________ (H)____________________________

FINANCIALLY RESPONSIBLE PARTY'S NAME (if different from client):
____
D.O.B.:______________________________

ADDRESS:____
PHONE:(M)____________________________(H)__________________________________

PLEASE COMPLETE IF YOU ARE COVERED BY INSURANCE:

INSURANCE COMPANY:_____________________________
POLICY/CERTIFICATE #:_____________________________TYPE OF PLAN:__________________

SUBSCRIBER'S NAME:______________________________
RELATIONSHIP TO SUBSCRIBER/POLICY HOLDER:__________________
NAME OF GROUP INSURED (employer):____
EMPLOYER' S ADDRESS:____

FEE AGREEMENT

FEE PER SESSION: $150.00

NO INSURANCE: I agree to pay my fee at the time of each visit unless other specific arrangements have been made.

INSURANCE: To the extent possible, our office will attempt to collect fees from your medical insurance. If your insurance doesn't cover the full cost of the service, you will be billed and agree to pay the unpaid balance, unless I have an agreement with your health plan to accept their reimbursement as full fee. It is understood that you will pay the fee, including co-payment and any deductible amount, at each session and then submit receipts for reimbursement from your insurance company unless other specific arrangements have been made. When your funds for mental health services have been exhausted for the year, it is understood that you will pay the fee each session.

Cancellation Policy:

I UNDERSTAND THAT I WILL BE CHARGED A LATE CANCELLATION FEE IF I MISS A SCHEDULED APPOINTMENT WITHOUT GIVING AT LEAST 24 HOURS NOTICE OF CANCELLATION.

Authorization:

I AUTHORIZE THE THERAPIST TO RELEASE TO MY INSURANCE COMPANY NECESSARY INFORMATION ON ME/MY CHILD IN ORDER TO RECEIVE REIMBURSEMENT. THIS INFORMATION IS TO BE CONSIDERED CONFIDENTIAL.

___________________________________ ________________________________
Signature of Client/Parent/Guardian Signature of Therapist

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Date