



THERAPY FINANCIAL AGREEMENT

By signing below, you are accepting the terms and services and office policy as follows:

You understand that fees for services are billed at the following rates:

- Initial Visit: \$200
- 45 – 50 minute Therapy Session: \$180
- 30 – 45 minute Therapy Session: \$170
- 15 – 30 minute “Check-In” Session: \$150
- 45 – 50 minute Family Therapy Session: \$225

If you are in crisis, do not wait for your therapist to return your call. Please go to your nearest emergency room or call 911. This practice does not provide crisis intervention or on-call services at this time.

_____ (Initial)

If you need to discuss an issue over the telephone between sessions that is going to take more than 10 minutes, we ask that you schedule an appointment so that you can be given the attention and time that you deserve. Phone calls should be reserved for scheduling and billing issues. Should the call involve a non-scheduling or billing issue or if the conversation exceeds 10 minutes a \$50 fee will be incurred. An additional \$50 will be billed for each additional 10 minutes following (first 10 minutes: no charge; second 10 minutes: \$50 charge; third 10 minutes: a total of \$100 charge, etc.).

_____ (Initial)

Additional services, such as telephone consultations, letters, additional reports, and other fees will be billed at a pro-rate of time based on \$50 per hour.

_____ (Initial)

All missed appointments, or appointments not cancelled within 24 hours, will be billed the ‘no-show’ fee of \$100. Missed or cancelled appointments are not billable to your insurance company, and will be charged directly to you.

_____ (Initial)



Showing up to an appointment 15-minutes after the scheduled time will be considered a late cancellation and is subject to the late cancellation fee.

_____ (Initial)

Payment by personal checks will not be accepted. All payments will be made through credit card or electronic payment.

_____ (Initial)

Unless otherwise agreed to in writing, you understand that payment is due by the date the service is provided. A \$15 late fee will be applied for each week the fee is overdue. Services will cease after two consecutive non-payments. You will be discharged from the clinician's care after 90 days of non-payment and/or non-contact.

_____ (Initial)

If this account is referred to any agency or attorney for collection proceedings, you agree to pay costs incurred in the collection of this account, including but not limited to attorney's fees in the amount of 50% of your account balance at the time that account is placed.

_____ (Initial)

Signature of Guarantor/ Financially-Responsible Party: _____

Printed Name: _____

Client Signature: _____

Date: _____

By typing my name, and checking this box, I confirm that I am authorizing this form.