**FINANCIAL AGREEMENT - OUT OF NETWORK/SELF-PAY**

Client Name: Birth date:

Address:

Name of Person Responsible for Payment:

Address and phone number:

Agreed upon fee per session:

Note:

* Payment is due at the onset of each session
* Acceptable forms of payment are cash, check or credit card.
* A monthly summary of your payments will be forwarded to you for your records
* If you are choosing to self-pay even though you may have health insurance coverage, please be aware that you cannot submit these expenses to your health insurance later date.
* If you choose to switch from self-pay to utilizing health insurance (if I am in your health insurance network) you must inform the provider of your intention to utilize health insurance at a minimum one week in advance of your session.
* **Cancellation is required 24 hours in advance of your appointment. Late cancellation fee is $120.00. Health insurance is not billed for late cancellations/ missed sessions and cannot be submitted to insurance for reimbursement).**
* **A $35 fee will be charged for retuned checks**

I have read, understood, and agree to the above outlined financial agreement.

Client Name: Client Signature: Date:

Client Name: Client Signature: Date:

Parent/Guardian: Parent/Guardian Signature: Date:

Parent/Guardian: Parent/Guardian Signature: Date:

My signature below indicates that I have discussed this form with you and have answered all questions you have regarding this information

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Therapist’s Signature Date

Revised 11/18/2018