Client Name: _____

Financial Policy: Private Pay Agreement

Thank you for choosing us as your mental health care provider. We are committed to your therapy being successful.

- You are responsible for all costs and fees associated with your therapy. You understand that we will not be billing an insurance plan for any of your visits and/or services. If you gain insurance coverage in the future, please let us know immediately and request a new financial agreement. **Claims will not be submitted retroactively** for dates of service that fall under your Private Pay Agreement.

- Payment is required at the time of service. **I, _____, agree to pay $200.00 for my initial session, and $150.00 per future routine session.** I understand that if I do not provide payment in full at the time of my session, I will not be able to be seen, and will be assessed a no-show fee.

- We reserve the right to assess late charges and/or turn accounts over to collections with past due balances over 30 days in age.
    - If I fail to make payment within sixty (60) days after the date of service, I agree to pay a rebilling charge of one and one-half percent (1.5%) per month, which is an annual percentage rate of eighteen percent (18%) which will be charged on the unpaid balance of my account beginning sixty (60) days after the date of service. The minimum rebilling charge is $7.00

- There will be a $35 service charge on all returned payments.

Please let us know if you have any questions or concerns.

I HAVE READ THE FINANICAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ Date: _____

Signature of the Client or Responsible Party

_____

Printed Name