

Patient Payment Responsibility and Agreement

Name of Patient _____

Please Read and Initial Each Below:

_____ I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members. I understand that payment is due at the time services are rendered unless special arrangements have been made. Length of time for therapy sessions are 1 hour for an initial consultation and 45 minutes for follow-up sessions.

_____ Because my time has been reserved exclusively for me and/or my family members, I understand that I am required to provide at least 24 hours' advance notice if unable to keep the scheduled appointment. In the event that I do not provide 24 hours' advance notice, I am financially responsible for the reserved appointment at the standard therapy hourly rate. For testing and extended sessions that are not cancelled within the time frame, I am aware that I am responsible for the number of hours blocked. We may make exceptions and waive the fee at our discretion for emergency or unusual circumstances. There may be a time when your therapist may need to cancel your appointment for an emergency; we will make every effort to reschedule you in an appropriate time frame. As a courtesy, the first 2 no shows/late cancellations will be charged at \$100.00 and all other no shows/late cancellations will be charged the full therapy rate.

_____ In order to provide effective treatment, consistency of attendance of scheduled appointments is important. Our office policy is that three (3) No Shows or Late Cancellations (less than 24 hours' notice) of scheduled appointments may result in termination of therapy or testing/assessments. If therapy or testing is resumed, then a credit card on file will be required and billed at the time of the cancellation or no show.

_____ In order to be flexible and responsive, many of our therapists are available for phone sessions and to speak with you at times when necessary. Please be advised, however, that all calls exceeding ten minutes will be billed in a pro-rated fashion on the basis of your session fee.

_____ I understand that charges will be added to my account for other professional services rendered. This charge will be in increments of 15 minutes and we will always discuss additional charges with you. Other professional services include extended contact via email, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us.

I fully understand and agree to the above policies and conditions. This supplements previous agreements I may have signed. A copy of this agreement is available upon request.

Patient/Parent/Guardian Signature _____ Date _____