Professional Services and Policies
Agreement Summary and Consent

I, ______________________________________, understand and agree to the following:

Review of HIPPA Privacy Notice Initials____________

Receipt of Psychotherapy-Client Service Agreement Initials____________

Fee Policies and Good Faith Estimate Initials____________

Unless otherwise arranged, I will provide payment in full at the time of service. Payment may be made with checks. In the event of a returned check, I understand that I will be responsible for reimbursement of the check/charge amount plus payments of any applicable service charges. Standard sessions are **$135** for a 50 minute session.

Insurance Initials____________

I authorize payment of medical benefits from my insurance company to Family Education & Services, LLC for all services rendered. I authorize this therapist to file insurance claims for the cost of services rendered. I authorize this therapist to submit to my insurance company or their representative any clinical information about my diagnosis and treatment that is necessary to authorize services and/or to process these insurance claims. I understand that I am responsible for knowing my own insurance coverage and limitations and when precertification is required. I understand that said benefits are not a guarantee of payment and that I am responsible for the entire bill including any deductibles or expenses the insurance does not cover.

Missed Sessions Initials____________

I am responsible for the full cost of any scheduled appointment that I cancel or miss **without a minimum of 24 hours** advanced notice. These charges are not covered by insurance plans. There will be a charge of $135.

Emergencies Initials____________

I understand that this office does not provide emergency services. In the event of an emergency, I know to contact the appropriate emergency service 911 (police, fire, hospital). My emergency contact will be contacted as well.

______________________________________ ____________________

Client Signature Date

Therapist Signature

Date