FINANCIAL POLICY

Below are the terms of agreement regarding payment for sessions with _____ (*therapist/practice name*).

1. Session fees are based on a clinical hour, which is defined by insurance providers as 45-50 minutes with the therapist or mental health professional.

2. If I, the client, fail to appear for an appointment without a 24-hour notice of cancellation, appointment fees will be charged and I will be responsible for payment.

3. I understand if I am late to a session, that session will end at the time originally scheduled. It is my responsibility to arrive on time.

4. Services including phone calls, emails, record reviews, and professional consultations at times other than the scheduled therapy session are the client's responsibility. These services will be billed per quarter of an hour.

5. I authorize my health insurance to provide payment of benefits to _____ (*therapist's/practice's name*).

6. I understand records of my treatment may be shared with _____ (*client's insurance company*) when necessary to process claims.

7. I understand I am responsible for payment if my insurance company declines payment.

I have reviewed this document and understand the above statements.

_____

Signature Date

_____

Printed name