Explanation of Fees

Client Name: _____ Date: _____

To ensure transparency and clarity, this form includes an explanation of the fees and financial aspects of [practice name]. Please review the following information and ask any questions you may have before proceeding with treatment.

Fee Structure

Individual Therapy Session (50 minutes): $_____

Couples / Family Therapy Session (50 minutes): $_____

Group Therapy Session (90 minutes): $_____

Initial Assessment / Evaluation Session (75-90 minutes): $_____

Extended Sessions (beyond scheduled session time): $_____ per additional ____ minutes

Payment Methods

We accept the following payment methods:

___ Cash

___ Check

___ Zelle

___ Venmo

___ Credit/Debit Card

___ Electronic Bank Transfer

Insurance Coverage

Please note [practice name] does not directly bill insurance companies. If your insurance plan covers out-of-network mental health services, we can provide you with a superbill (a detailed receipt) that you can submit to your insurance company for potential reimbursement. It is your responsibility to contact your insurance provider to verify your coverage and determine the reimbursement process.

Cancellation Policy

[Practice name] has a ____-hour cancellation policy. If you need to cancel or reschedule your appointment, please notify us at least ____ hours in advance to avoid being charged for the session. Late cancellations or missed appointments may be subject to a fee of $_____.

Sliding Scale Fee

Financial circumstances vary, and if you are experiencing financial hardship, [practice name] offers a limited number of sliding scale fee slots based on availability. Please discuss this with your therapist during your initial session if you wish to explore this option.

Fee Adjustments

Fees may be subject to periodic adjustments. [Practice name] will provide you with reasonable notice regarding any fee changes.

By signing below, you acknowledge that you have read, understood, and agree to the terms outlined in this form. You also understand that you are responsible for payment of the fees associated with the services received.

Client Signature: _____ Date: _____

Client Printed Name: _____

Therapist Signature: _____ Date: _____

Therapist Printed Name: _____

Please retain a copy of this form for your records. If you have any questions or need further clarification, please let us know.

Note: This form is for informational purposes only and does not constitute a legal contract.