Financial Agreement for Therapy Services

This financial agreement outlines the terms and conditions regarding fees, payment, and cancellations for therapy services provided by our practice. Please read carefully and sign at the bottom to acknowledge your understanding and acceptance of these terms.

Telehealth Services Cancellation Policy

Your Telehealth appointment time is reserved exclusively for you. To ensure fairness and respect for all clients, the following cancellation policy applies:

- **Cancellation Notice**: You must provide at least 24 hours' notice to cancel your appointment. Failure to do so will result in a cancellation fee of $100.
- **No-Show Appointments**: If you do not show up for a scheduled appointment without prior notice, you will also be charged a $100 fee.
- **Insurance Coverage**: Please note that your insurance company does not cover fees for late cancellations or missed appointments. These fees are your responsibility.
- **Policy Enforcement**: This cancellation policy is standard in the mental health field and will be strictly enforced. No exceptions will be made.

Fees and Payment for Services

You are required to pay for therapy services and any other applicable fees. Below are the key financial policies regarding payment:

Payment for Services

- Payment is due at the time of your session.
- You are responsible for confirming your therapy costs prior to beginning services.
- If using insurance, confirm coverage for the type of therapy, including Telehealth sessions, and whether your provider is in-network or out-of-network.

No-Show and Late Cancellation Fees

- As outlined above, fees apply for missed or late-cancelled appointments and are not covered by insurance.

Balance Accrual

- Any unpaid balance will remain due until paid in full. If you are unable to pay, please inform your provider immediately to discuss potential payment plans or sliding scale options.
- Unpaid balances may be sent to a collections service if necessary.

Administrative Fees

- Additional fees may apply for administrative tasks, such as:
  - Writing letters or reports at your request.
  - Consulting with another healthcare provider or professional outside of normal case management practices.
  - Preparation, travel, and attendance at a court appearance.
- These fees will be outlined in your specific fee agreement and are due in advance.

Insurance Benefits

It is your responsibility to confirm your insurance benefits prior to starting therapy. This includes:

- Verifying coverage for in-person and Telehealth sessions.
- Understanding your financial responsibility for deductibles, copays, or coinsurance.
- Determining whether services are covered when your provider is in-network or out-of-network.

Sharing Information with Insurance Companies

- If you choose to use insurance benefits, personal information must be shared with your insurance company. While insurance companies typically maintain confidentiality, they may share information as required by law or for administrative purposes.

Covered and Non-Covered Services

- In-Network Providers: Your insurance plan may cover part or all of the therapy cost. You are responsible for any remaining portion, such as deductibles, copays, coinsurance, or non-covered services.
- Out-of-Network Providers: If your provider is out-of-network, you must pay all fees at the time of service. Your provider may assist you in filing for reimbursement, but the responsibility for payment remains with you if reimbursement is denied.

Payment Methods

- Credit or Debit Card on File: A valid credit or debit card must be kept on file. This card will be charged for fees due at the time of service and for any additional fees unless other arrangements have been made in advance.
- Updating Payment Information: It is your responsibility to update your card information if it changes or has insufficient funds.

Acknowledgment and Agreement

By signing below, you acknowledge that you have read and understood this financial agreement. You agree to abide by the policies outlined, including payment obligations, cancellation fees, and insurance-related responsibilities.

Client Name: _____
Client Signature: _____
Date: _____
Provider Name: _____
Provider Signature: _____
Date: _____