heartsand**minds**health
licensed mental health services in NOVA and Metro DC

Policies and Financial Agreement

Client Name: ______________________________

Parent or Legal Guardian: ______________________________
(if applicable)

Billing Address: ______________________________

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The following agreement is designed to establish a clear, mutual understanding of the business side of our work together. Please feel free to ask about anything that is unclear and mention any questions or concerns that arise.

Fee Information: Individual consultation and therapy lasts approximately forty-five minutes and the cost is $150.00 per individual session. The fee for couples therapy is $170.00 per fifty minute session. Group therapy is $75.00 for a 75-minute session. A fee reduction may be possible in cases of financial hardship to continue treatment while the client's finances are realigned. Special services, such as court appearances, are billed at an hourly rate of $250 including travel and preparation time. The cost for treatment may increase in accordance with expenses and market value.

Fees are due at the time of services in the form of cash, credit card, or check and the client is ultimately responsible for all charges. Statements indicating date of visit, charge and payment are provided at each visit. Unless otherwise arranged, it is the client's responsibility to forward this invoice to their insurance company for reimbursement.

Missed Appointments: Scheduled appointments are made one to two weeks in advance, and a given hour is considered blocked for a particular client. A late cancellation usually results in an open hour, inconvenience, and a loss of revenue. Therefore, ***no-shows and cancellations made less than 48 hours in advance will be billed at the full rate of service***.

I acknowledge and accept full responsibility for this account and guarantee payment of all charges against this account. In the case of third-party insurance participation, I authorize the release of any medical information necessary to process the claim. I request that payments be made directly to **hearts**and**minds**health on my behalf.

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Client Signature | Printed Name | Date

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Co-Signature | Printed Name | Date

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