heartsandmindshealth

licensed mental health services in NOVA and Metro DC

Financial Policy and Service Agreement

Client Name: _____

Parent/Guardian:
(if applicable) _____

Billing Address:

_____

_____

Phone: _____ **e-mail:** _____

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 is billed at a rate of $160.00 per session. Couples and family therapy is billed at $180.00 per session. Sessions run approximately 45-50 minutes. Pro-rated, extended sessions are also available through prior arrangement. Group therapy is $80.00 for a 75-minute session. A fee reduction may be considered in cases of financial hardship for continuity treatment while the client's finances are realigned. Special services, such as court appearances, reports, and presentations are billed at an hourly rate of $250 (or fraction thereof) including travel and preparation time.

Fees are due **at the time of service** and the client or their designated guardian is responsible for all charges. Statements indicating date of visit, charge and payment are provided upon request at each visit. Such payment receipts also include medical and diagnostic codes for insurance or medical savings plan reimbursement. **it is the client's responsibility to forward claims to their insurance company according to plan guidelines.**

Forms of Payment: Cash, check, debit or credit card are accepted for payment. **Credit card processing fees are waived for clients who elect to have their credit card information on file** for automatic processing at time of service.

CREDIT CARD AUTHORIZATION (OPTIONAL): _____ Signature

_____ - _____- _____ - _____ EXP: ____/____ CODE _____ ZIP CODE _____

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 accordance with this agreement.

_____

Client Signature Printed Name Date

_____

Co-Signature Printed Name Date

© heartsandmindshealth 2018