FINANCIAL AGREEMENT AND INSURANCE INFORMATION

Name:_____ **Date of Birth:**_____

Doctor/Therapist:_____

Insurance Information:

Primary Insurance_____

Insured's Name_____ Insured's Date of Birth_____

Insured's Address_____

Insured's Phone Number_____

_____ _____

_____

City State Zip Code

Insured's Social Security Number:_____

Gender: □ Male □ Female

Insured's Policy Number:_____

Insured's Relationship to Client: □ Self □Spouse □Parent □Other

Insured's Employer_____

_

Employer's Address_____

Secondary Insurance_____

Insured's Name_____ Insured's Date of Birth_____

Insured's Address_____

Insured's Phone Number_____

_____ _____

_____

City State Zip Code

Insured's Social Security Number:_____

Gender: □ Male □ Female

Insured's Policy

Number:_____

Insured's Relationship to Client: □ Self □Spouse □Parent □Other

Insured's

Employer_____

_

Employer's
Address_____

FINANCIAL AGREEMENT

Standard Fees and Charges per Hour (Licensed Psychologist Level):

- Individual and Family Therapy, 16-37 minutes: $150
- Individual and Family Therapy, 38-52 minutes: $175
- Individual and Family Therapy, 53-60 minutes: $190
- Mental Health Assessment: $235
- Mental Health, Group Therapy, 90 minutes: $125
- Psychological Testing, 60 minutes: *price varies

*Price may vary based upon test type & battery performed; please check with your provider for an exact rate.

Standard Fees and Charges per Hour (LPC Level):

- Individual and Family Therapy, 16-37 minutes: $135
- Individual and Family Therapy, 38-52 minutes: $160
- Individual and Family Therapy, 53-60 minutes: $175
- Mental Health Assessment: $200
- Mental Health, Group Therapy, 90 minutes: $90

If you would like to self-pay, please negotiate an hourly rate with your therapist.

Agreement to Pay:

- I understand that I am financially responsible to my provider for services rendered.
- I agree to pay the co-pay, coinsurance, and any deductible stipulated by my insurance plan.
- Payment is due at the time of my appointment unless other arrangements have been made.
- It is my responsibility to inform my provider of any changes that affect the billing or charges to my account. This includes third-party payers, income, or family status.
- I understand that standard collection procedures will be followed if payment is not made.

Initial for Above Statements_____