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_______________