Payment Agreement

1. Out of Network Insurance: □

   Payment for the service is due in full at the time of the session. A receipt will be provided for you at the end of each session which can be used to seek reimbursement from your insurance provider. Providing this receipt is not a guarantee of reimbursement; for more information contact your insurer regarding your policy and benefits.

   Please note that seeking reimbursement from insurance for mental health care requires a DSM-V diagnostic code. Checking this box and signing below indicates full understanding and consent for personal information regarding your treatment to be communicated to the insurer per their requirements. For more information contact your insurance provider.

2. Self-pay: □

   Payment for this service will be the sole responsibility of the client or the party named below. The agreed upon fee for this service is $160 per 50 min. session unless otherwise arranged and noted here: _____

Name(s): _____

I am/we are paying for:

□ myself/ ourselves

□ other: _____

By signing I/we accept responsibility for the cost of the psychotherapy services. I/ we understand that this includes late cancellation and no-show fees.

Signature: _____ Date: _____

Signature: _____ Date: _____