

Jose Morell, LMHC, LPC, LADC I, LLC

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**Waiver of Insurance Billing for Private Pay Clients**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have chosen to be a private pay client. This means that at the time of service you will be paying by cash or credit card. I understand that my therapist will not bill insurance for services provided under this arrangement. I am also aware that no forms will be produced now, or in the future, for my therapist to submit for insurance billing.

Agreed Upon Private Pay Rate will be as followed: $140 for intake and $120 for subsequent 45 – 50 minute sessions. Please Initial here \_\_\_\_\_\_\_

I agree to:
1) Pay at the time of service
2) Waive insurance billing by Jose Morell, LMHC, LADC I, LLC
3) Notify Jose Morell, LMHC, LADC I, LLC of a desire to change this agreement prior to private payment for a session

Further, I attest that I do not have Medicaid for insurance purposes, as Federal law disallows Medicaid clients from paying out of pocket for these services.

Client name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_