THE THERAPY CENTER FOR WELLNESS & RECOVERY LLP

NOTICE OF AND AGREEMENT TO PAY FEES

Name ____ Date of Birth__________________

Notice of Fees: The provider charges a fee for providing services. The standard fee is $188.00 for a 50-minute session; however, certain managed care and insurance company contracts may have been pre-set fees. If your health insurance policy does not provide coverage for the Provider's services or denies coverage, then you are responsible for payment of fees. There is also a cancellation fee for failing to attend a scheduled appointment without giving a 24-hour notice of cancellation, which is not covered by insurance.

In order to set realistic treatment goals and priorities, it is important for you to understand what resources you have to pay for your treatment. If you have a health insurance policy, it may provide coverage for mental health or substance abuse treatment. It is very important that you find out what your health insurance policy covers. As a convenience to you only, the Provider will assist you in applying for health insurance benefits for which you have coverage.

In connection with the submission of a claim, most insurance companies require you to authorize the Provider to provide them with a clinical diagnosis. Sometimes the Provider has to provide additional clinical information, such as treatment plans or summaries or copies of the entire record in rare cases. This information will become part of the insurance company files and will likely be stored in a computer. We have no control over the use of this information after it is provided to them.

Client Acknowledgement: I acknowledge and agree that:

a. I am responsible for and will pay the fees for services rendered in the event that I am a cash- pay client or in the event my health care insurance company denied a claim for payment.
b. I am responsible for and will pay the cancellation fees for failing to attend a scheduled appointment without giving 24-hour notice of cancellation.
c. I am responsible to determine what treatment my health insurance policy covers and that any assistance provided to me applying for any health insurance benefits to which I am entitled is provided to me only as a convenience and does not guarantee coverage or otherwise obligate the Provider in any way.
d. That the Provider is authorized to use and disclose information required or requested by my health care insurance company, including but not limited to the information described above and that this information will become part of the insurance company files and will likely be stored in a computer and that the Provider has no control over the use of this information after it is provided to them.
e. I have been given a signed copy of this document

Signature of patient ____

Date ____

Signature of Parent of Guardian____

Date ____