I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the therapist insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Client or Guardian ---------- Date ----------

Primary Insurance:

Name of Insured: _____Insured's Birthday: _____

Insured's Address: _____

City, State, Zip _____

Phone: _____Relationship to client: _____

Employer: _____Insured SS #: _____

Insurance Company _____ID & Group#:_____

Insurance Phone #: _____

Client Name: _____

Client's Birthday: _____Cient SS #:_____

Financial Policy and Agreement

Cancellation

If cancellation is less than 24 hours in advance of your appointment, you agree to pay the cancellation fee of $100.00 for an Initial Appointment and $90.00 for follow up appointments. The same fees apply if you do not show up for your scheduled appointment. Virtual appointments - Client absence more than 10 minutes after the scheduled time is subject to a no show fee and will need to be rescheduled.

I authorize Sensible Counseling to charge my credit card listed below, which will be kept on file, the cancellation fee. _____ Initial Here

Insurance

Any fees not covered by your insurance company will be charged to your credit card on file. Fees include but are not limited to copayments, coinsurance, and insurance deductibles.

I authorize Sensible Counseling to charge my credit card listed below, which will be kept on file, any amounts not covered by my insurance company including but not limited to copayments and insurance deductibles.

_____Initial Here By signing below, I acknowledge and agree to the Financial Policy and Agreement. I further instruct my credit card issuer to honor any charges subject to the Financial Policy and Agreement.

Signature of Client or Guardian Date:

Please provide the following information:

Name on Card _____ Visa ___ MasterCard ___ Discover___ Amex___

Credit Card Number _____ Exp Date _____ Sec Code _____

Billing Address_____City_____State_____Zip_____

FEES: Therapy is a commitment of time, energy and financial resources. If you have health insurance, it is important for you to verify your mental health benefits so you understand your coverage prior to your appointment. **You are responsible for all costs not covered by your insurer.** Some insurance companies require a precertification before the first appointment or they will not cover the cost of services. Current fees are as follows:

● Patients with insurance: the negotiated rate with each insurance company with In Network Discounts according to your insurance coverage.

● Self pay rates, when insurance is not available:

1 Hour Individual Psychotherapy (53 minutes) $100 Intake/Initial Appointment
1 Hour Individual Psychotherapy (53 minutes) $90 Follow Up/ Regular Appointment Sessions
1 Hour Psychotherapy (53 minutes) for couples session is $100

● All written letters, or treatment summaries $60.00

● No Show/Late Cancellation Fees: $100 per Initial Intake Appointments/ Couples Session
$90 per Individual Ongoing Psychotherapy Sessions
** More than 10 minutes past scheduled appointment time for Virtual Session is subject to a No Show Fee and rescheduling.

● $25 per 15 minutes for phone calls over 10 minutes in length, email correspondence, reading assessments or evaluations, writing assessments or letters, and collaborating with necessary professionals (with your permission) for continuity of care.

All costs for services outside of session will be charged to the credit card on file at the time services are rendered. **An on file credit card is required at Sensible Counseling and will be automatically charged at the time of a missed or no show cancelation fee. This card will also be charged for any invoices billed that are 30 days past due. If fees for services are not paid within 30 days and or the credit card on file has insufficient funds and the client is unresponsive to communication in the matter, a client account will be sent to a collection service. All balances after 30 days will be subject to a 3% monthly interest rate. All fee's, copays and coinsurance are due at the time of the session and will be charged to the credit card on file.**

COPIES OF MEDICAL RECORDS: Should you request a copy of your medical records, the cost is $20 and $0.50 per page. Payment for your medical records will be due prior to or upon receipt. Please allow at least 2 weeks to prepare medical records.

By signing below, I acknowledge and agree to the Financial Service Fees Agreement.

Signature of Client or Guardian **Date:**