Today's Date: _____

Acknowledgements and Fee Agreement

Non-Insurance Clients

Acknowledgements

- I certify to the best of my knowledge, that all of the information provided in these documents is true and correct.
- I acknowledge that I have received a copy, as well as read and understand my therapist's informed consent/treatment agreement.
- I have received a copy of the notice of MBH Wellness Clinic privacy practices, and I have read and understand my rights under HIPAA regarding my protected health information.
- I understand that I am responsible for all fees incurred and agree to pay those fees at the time of service.
- I do not have insurance, or do not wish to/cannot file with my insurance company. I understand that I may receive a self-pay discount for providers that accept insurance. I further understand that such a discount does not apply if I choose to file insurance at a later date.

_____ Please initial that you understand the above acknowledgements.

Fee Schedule

I understand that I will be charged $140 per hour session out of pocket unless otherwise negotiated with my therapist.

Initial Diagnostic Session _____

50-60 minute individual session _____

50-60 minute family session _____

90 minute session _____

Court appearance per hour _____

Each additional 15 minutes in session or over the phone, text, email _____

Any documentation preparation will be charged based on the above rates

No Show and Late Cancellation Policy

- I understand that if I do not show to an appointment, I will be charged 100% for a 50 minute session.
- I understand that if I cancel my appointment with less than 24-hours' notice, I will be charged 100% for a 50 minute session.
- I understand that if I cancel my appointment with 24-48-hours' notice, I may be charged 50% for a 50 minute session.

_____ Please initial that you understand the above policy.

By signing my name below, I certify that I have read the above information. My signature also certifies my understanding of and agreement with the above policies. I understand I am responsible for all charges. A photocopy of this document is as valid as the original. You may receive a copy of this document upon request.

_____ _____
Client (or parent/guardian if minor) Signature Date

_____ _____
Witness Signature Date

_____ _____
Therapist Signature Date