Today's Date: ____________________

Acknowledgements and Fee Schedule

Insurance Clients

Acknowledgements

- I certify that 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 authorize the release of any medical information necessary to process my insurance claims.
- I authorize benefits to be paid directly to MBH Wellness Clinic.
- I understand that my insurance will be billed $140 per hour session.
- I understand that my insurance company may not pay for the full amount of my treatment, and that I am responsible for all fees incurred regardless of insurance payment (copays, deductible, etc).
- I understand that my insurance company may require authorizations or other information and that all such requirements are my responsibility.

________ Please initial that you understand the above acknowledgements.

Fee Schedule

- If I have a deductible, I understand that I will be charged $140 per hour session out of pocket unless otherwise negotiated with my therapist.
- I understand that until my deductible is met, I agree to pay _______.
- I understand that most insurance companies pay for one 1 hour session, and that I will be charged a rate of ______________ for each additional 15 minutes in session or over the phone, text, email.

________ Please initial that you understand the above fee schedule

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 not paid by insurance. 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