

**Acknowledgements, Fee Schedule, and Cancellation Policy**

**Acknowledgements:**

* I certify to the best of my knowledge that all the information provided to MBH Wellness Clinic and its employees is correct.
* I have received a copy, as well as read and understand my therapist’s consent and treatment agreement.
* I have received a copy of privacy practices for MBH Wellness Clinic and I understand my rights under HIPAA regarding my protected health information.
* I understand that if my therapist has a reason to suspect harm of self or harm to others, that my therapist will contact the appropriate authorities to assure safety.

\_\_\_\_\_ Please initial here that you have read and understand the above acknowledgements.

**Fee Schedule and Insurance Policy:**

* I authorize insurance benefits to be paid directly to MBH Wellness Clinic.
* I understand my insurance company will be billed $140 per 55-60-minute session.
* If I have a deductible, I understand that I will be charged $140 (unless otherwise negotiated with my therapist) per 55-60-minute sessions out-of-pocket until the deductible has been met.
* Negotiated Pay Rate between this client and this therapist: $\_\_\_\_\_\_\_\_
* I understand that most insurance companies pay for 55-60-minute sessions and I will be charged an additional $35 (or 25% of negotiated rate) per 15 minutes over the allotted timeframe.
* I understand that my insurance company may not pay for the full amount of my treatment and I am responsible for all fees incurred regardless of insurance payment, such as copayments and deductible.
* I understand that my insurance company may require authorizations or other information prior to payment for services rendered and it is my responsibility to attend to those requirements, such as getting a pre-authorization letter from my primary care physician or psychiatrist.
* I understand if I decide to pay out of pocket, I will be billed $140 per 55-60-minute session (unless otherwise negotiated with my therapist for future sessions).
* I understand, if I am a patient of Dr. Misty Smith, the couple’s rate is $150 for

55-60-minute session and $80 for 30 minutes unless otherwise negotiated.

\_\_\_\_\_ Please initial here that you have read and understand the above fee schedule and insurance policy.



**No Show and Late Cancellation Policy**

* Should I cancel a session with 24 -48 hours’ notice in advance to therapist or office manager, I will be charged a cancellation fee of 50% for 50-60 mins session.
* Should I cancel a session with less than 24 hours’ notice in advance to therapist or office manager, I will be charged a cancellation fee of 100% for 50-60 mins session.
* I understand that a no-show appointment will result in a $140 charge to my credit card on file.
* I understand that if I have a no-show or late cancellation balance on file, settling this amount will be necessary prior to setting another appointment.
* I understand if my therapist has a reason to suspect that I am a danger to myself or others and you do not show up for an appointment, that therapist will contact the authorities or your approved emergency contact.
* I understand that I may lose the privilege of holding a regularly scheduled session time if I no show or late cancel consistently in one calendar year or as outlined by your counselor.

\_\_\_\_\_ Please initial here that you have read and understand the above No Show and Late Cancellation policy.

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Client or Guardian of Minor Client Printed Name

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Client or Guardian of Minor Client Signature Date

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Witness Signature Date

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Therapist Signature Date