FINANCIAL AGREEMENT

Client(s) Name:_____

FINANCIAL AGREEMENT:

1. I understand that services are provided on a fee for service basis and that payment (either cash, check or credit card) is due at the beginning of each session.

45 minute session $100

2. If I fail to keep an appointment without notifying provider **24 hours in advance**, I realize that I will be charged **a $50 late cancellation fee**. See "Office Policies" for additional information.

3. I understand that there will be a $20.00 handling fee for all returned checks. I understand that I am financially responsible for charges not covered by this authorization.

4. I understand that if I request a claim form for out-of-network insurance reimbursement that this may limit confidentiality as the insurance company's case manager reviews my claims and has access to my clinical information.

_____

Client/Guardian Signature Date

_____

Client/Guardian Signature Date

_____

Megan Bearce, LMFT Date

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