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FINANCIAL POLICY

As part of an effort to provide the best possible mental health care to you, I would like to explain my financial policies in advance.

Client Name:_____ Date:_____

Name/Relationship of Financially Responsibly Party:_____

1. Your health insurance is a contract between you, your insurance company and your employer. I will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered or reimbursable charges, or coordination of benefits. My professional services are rendered to you, not the insurance company. Therefore, payment for services is ultimately your responsibility.

2. All fees incurred are due at the time of your visit. I accept cash, Visa, MasterCard, American Express and Discover cards. Credit cards will be kept on file and charged for the appointment or missed session within 48 business hours of the appointment.

3. Cancellations must be provided at least 24 hours in advance of the scheduled appointment. Cancellations not made prior to this timeframe are subject to a late cancellation and/or no show fee of $75.00.

4. It is your responsibility to keep the card on file up to date. If your card is declined, attempts will be made to continue to charge the card on file as well as to advise you about the decline and offer to accept an alternative payment method. I am not responsible for bank fees related to overdrafts or declined payments.

5. Accounts that are 90-120 days past due may be turned over for collection.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

Signature of Financially Responsible Party _____ Date _____

Effective 12/20/2025