Patient payment agreement

Thank you for the opportunity to help you meet your mental health goals. During the discussion of your treatment recommendation the following financial arrangements were made:

The cost of treatment is $35/session following 4 free sessions. .

- $45/ Session for session 9-12
- $55/ Session for session 13-16
- $65/ Session for session 17+

(If actively working to transfer and have appointment at a permanent facility price will remain at $35/Session)

_____ (Patient initials) I have discussed payment options and agreed upon a payment plan. I understand that I am responsible for payment of services rendered without applying any services to insurance. Payment will be due at the time of service.

As you know, it is this practice's policy to receive payment prior to completion of treatment. You have agreed to pay your patient portion of the treatment fee in the following way:

- Cash
- Check
- Credit Card (Subject to 4% processing fee)

If you have questions about your treatment plan or the choice of payment options, please do not hesitate to ask. We are here to help you get the healthcare you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

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