MIND AND BODY
COUNSELING ASSOCIATES

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THERAPY TREATMENT FEES

I, _____(print name), am aware that the fees for the services provided by
_____(therapist name) are as follows:

I understand that all fees are directly my responsibility to pay at the time of service. I understand that 24-hour notice is required for cancellations or I will be charged $100.00 for the missed session. Excessive cancellations or changing appointment times are disruptive to the therapeutic process as well as the therapist's schedule. I may be charged for any extra services requested. I understand that those charges will be discussed prior to services rendered. Services will not be rendered until fees have been paid.

Insurance companies will be billed and paid directly to Mind and Body Counseling Associates. I understand that I will be responsible for all outstanding monies not covered by the insurance company. For "Out of Network" insurance companies, paperwork can be provided (upon request) for you to submit a claim. Checks are accepted however, there will be a $50.00 charge for any returned check. If your account goes into Collections, there will be a 40% fee added to your balance.

I agree to take financial responsibility for my session(s). I will pay for services at the time they are rendered or in advance.

I authorize use of my credit/debit card by Mind and Body Counseling Associates for payment, outstanding monies owed, as well as, missed appointment:

Type (circle one): Mastercard Visa American Express

Card Number: _____Exp. Date: _____ CVV:_____

Cardholder Name: _____ Zip Code:_____

Client Signature_____ Date:_____