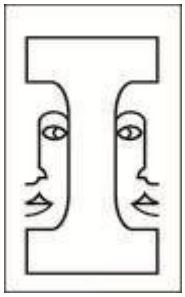

Insight Psychological Services, LLC

Financial Agreement

Client Name: _____ Date of Birth: _____

I understand that our uninsured fee for individual, couples, and family psychotherapy is billed at a rate of **$160 per session**. Uninsured clients are responsible for this fee at the time of service.

I understand that insured clients rates vary based on individual insurances. Insured clients are responsible for their co-pay/co-insurance/deductible at the time of service. Due to the rising cost of health care, insurance benefits have become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. As a courtesy to you , our office will pre-qualify your insurance coverage, in an effort to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommended services. This service is a **courtesy** and is **not** a guarantee of coverage.

If your insurance has not paid on an assigned bill within 90 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If it remains unpaid within 120 days, the balance becomes due and payable immediately.

As an Insight Psychological client, I understand that fees are due to Insight Psychological Services at the time of service in the form of cash, check, MasterCard, Visa, or Discover and that I am ultimately responsible for all charges. I also understand that an account 30 days past due will be subject to a $50 late fee. I understand that a $25 fee will be billed for any checks that come back with insufficient funds. Statements showing dates of visits, charges, and payments will be provided upon request.

I understand that cancellations must be made **24 hours in advance** to avoid a charge to my account. A same day cancellation, reschedule, or no-show will result in a $50 fee for regular appointments or a $75 fee for St. John and Psychiatric appointments. I am aware that missed appointments are not covered by insurance.

As an Insight Psychological client, I acknowledge and accept full responsibility for this account and guarantee payment of all charges against this account to Insight Psychological Services, LLC.

_____

Signature of responsible party/Date