

FINANCIAL AGREEMENT FOR PSYCHOTHERAPY SERVICES

DEMOGRAPHIC INFORMATION

Full Name: _____ Date of Birth: _____
Home Address: _____ City: _____ Zip Code: _____
Home Phone: _____ Cell Phone 1: h _____ Cell Phone 2h _____
Email: _____

GUARANTEE OF PAYMENT

Full payment is due at the beginning of each session unless other arrangements have been made. Please have your payment ready at the beginning of the session.

Cash and check are acceptable payments.

There will be a \$35 fee for returned checks. Cooperation is expected in this matter.

By signing this form, I agree to pay Karen Vedus Ed.S LMFT \$125 for each 60 minute couples therapy session and \$100 for each Individual therapy session. Couples sessions may be billed as 2 if covered under insurance. This provides adequate payment for more time if needed. I will be responsible for both copays if this is the case. I understand that if I cannot attend the next scheduled session or reschedule fo the same week, session will be marked as 'late cancelled' and I will be charged the full fee. Cancellation and Rescheduling policies will be instituted regardless of the reason for cancellation . Charging for cancellations is a business decision. In contrast to a physician or many other health professionals, my therapy fee is not just payment for a single service (often brief), but for a weekly session during an extended period of time. A period of time each week is put aside for my exclusive use.

I understand that if I miss more than 25% of my sessions in any 2 month period (2 sessions) , I will reassess my commitment to continuing in therapy.

I agree that I will not challenge any charge for cancellations or no-shows. I understand that if questions or concerns about any fees or payments, I am encouraged to discuss them openly with Karen Vedus at the beginning of treatment.

If I am utilizing health insurance benefits, I understand that I am authorizing Karen Vedus to use and/or disclose my Protected Health Information (PHI) process insurance claims, and receive payment from my insurance company or companies. I understand the information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or privacy law. I understand that it is my responsibility to obtain information regarding my mental health insurance benefits. I will not hold Karen Vedus liable for insurance non-payment due to misquoted benefits. I acknowledge that I am responsible to read and understand my benefit plan and for filing my insurance claims.

I understand that prior to any fee increase, I will be notified 60 days in advance.

Signature of Client:

_____ Date: _____

Signature of Spouse:

_____ Date: _____