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: _____