**Payment Agreement**

I hereby authorize Hope & Healing Counseling, LLC to disclose by telephone, facsimile, electronic data interchange, or by document delivery by carrier or postal service all or any part of my record as required to process claims for payment of services.

I give permission to Hope & Healing Counseling, LLC to perform diagnostic and/or treatment services. I authorize my insurance benefits to be paid directly to Hope & Healing Counseling, LLC. I also accept responsibility for payment of services I request, or which are required for my treatment, which may not be covered by my insurance. I am responsible for contacting my insurance company for initial authorization and verifying my mental health benefits.

*I understand that I am responsible for all fees applied to my account for treatment and services.*

**Payment – including co-pays, co-insurance, and/ or deductible amounts – are due at the time of service.**

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*Signature of Patient/Guardian/Legal Representative**Date*

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*Relationship to Patient*

**Cancellation/ Missed Appointment Charge**

***Please note there will be a $50.00 charge assessed to your account for any appointment missed or cancelled with less than a 24-hour notice.***

**THIS FEE IS NOT COVERED BY YOUR INSURANCE COMPANY.**

**Initials**

***Hope & Healing Counseling, LLC***

*1200 Valley West Drive, Suite 304-04*

*West Des Moines, IA 50266*

*(515) 421-4367*