Evergreen Clinical Associates
evergreenclinicalassociates.com
evergreenclinicalassociates@gmail.com

Currently, Evergreen Clinical Associates/Shawn E. Conn, MSW, LCSW is an out of network provider for _____ Insurance Company or you have elected to be a self-pay client. The agreed upon charges for your treatment with Evergreen Clinical Associates will be $_____ per session hour for a total of _____ hours per _____ for a total of $_____ per month. This amount is greater/less/the same than the participant may be charged by an in-network provider for their insurance. Payment is due by the _____ day of each month beginning on _____. After 2 consecutive months of non-payment, services will be discontinued. Services can be resumed once payment arrears have been paid or payment arrangements have been made.

By signing below, I affirm that I have read, understand, and agree to the terms mentioned above.

_____ _____
Client/Legal Guardian Signature Date

_____ _____
Therapist Signature Date