Healing Hidden Hurts

600 East Carmel Drive Suite 165
Carmel, In 46032
Phone: 888-349-1116 Fax: 855-794-5462

FINANCIAL CONTRACT

Thank you for choosing Healing Hidden Hurts as your service provider. We are pleased to be able to provide you with exceptional treatment services. Please be aware that if your insurance does not pay for the following services, you may be responsible for all costs of service at the following rates:

INDIVIDUAL THERAPY INTAKE (60 minute sessions)	$155.00
INDIVIDUAL THERAPY (45-50 minute sessions)	$130.00
COUPLES/MARITAL THERAPY (50 minute sessions)	$160.00
FAMILY THERAPY (50 minute sessions)	$160.00
GROUP THERAPY (50 minute sessions)	$60.00

I give my consent for Healing Hidden Hurts to file my insurance and release my mental health records as determined necessary for the filing of insurance reimbursement. I authorize release of payment of medical benefits to Healing Hidden Hurts. **Initial Here:** _____

These services are available and NOT billable to insurance; the need for these services will be determined on an individual case basis and may be discussed with your therapist for additional information. You will be responsible for costs of service at these rates:

COURT PREPARATION/TESTIMONY (per hour)	$250.00
PSYCHOLOGICAL TESTING (per hour)	$125.00
REPORT WRITING (per hour)	$125.00
CONSULTATION WITH OTHER PROFESSIONALS- i.e. teachers, attorneys, doctors (per hour)	$125.00
TRAVEL TIME (per hour) plus MILEAGE	$125.00

Initial Here:_____

FAILED OR LATE CANCELLED APPOINTMENTS (each) **$50.00**

Twenty-four (24) hour notice is required when canceling and rescheduling appointments. Clients not attending an appointment or failing to provide this notification may be charged $50.00 for these sessions. This fee is not billable to insurance. Repeated cancellations or failed appointments will result in termination from services.

Initial Here: _____

I agree that I am responsible for the payment of all co-payments, co-insurance, and all other fees to Healing Hidden Hurts for my/our participation. I agree to pay these fees at each scheduled session. I understand that failure to pay these fees will result in not being scheduled until full payment is made. I understand that non-payment of fees is a violation of this contract and will result in termination and possible further action by the court. If for any reason my account should become delinquent, I understand that I am responsible for all costs of collection including, but not limited to, collection fees, attorney fees and court costs.

Please provide Healing Hidden Hurts with your card(s) to copy.

Please check insurance coverage.

_____ Private Insurance (Primary Coverage)
_____ Private Insurance (Secondary Coverage)
_____ No Insurance; reduced pay rate (based on income)
_____ I chose not to file insurance, and I will pay full fees.

I, the undersigned, assume full responsibility for my/our fees and agree to the terms herein.

_____ _____
Signature of Responsible Party Date

_____
Printed Name of Responsible Party