**Financial Policy and Fee Agreement**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_Josh Baron LMSW\_\_\_\_\_\_\_\_\_\_

 (Client’s Name) (Therapist’s Name)

**Financial Policy**

The following is a statement of the financial agreement made between you and your therapist.

* You and your therapist will discuss your fee and the terms of payment during your first meeting
* In general, payment will be expected at the time of service.
* Payment can be made by cash, check, or confidential Venmo transaction.
* You will be responsible for all payment not cover by your insurance company (e.g. when meeting your deductible; if your insurance company pays less than what was expected and agree upon in the fee agreement).
* A charge may be issued for appointments that are cancelled with less than 24 hours notice or if you fail to come in for a scheduled appointment.

**Fee Agreement**

Diagnosis Code \_\_\_\_\_\_\_\_\_\_\_\_ Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_ Self Pay \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_ is the amount I agree to pay for each full session.

\_\_\_\_\_\_\_\_\_\_\_ is the amount I will pay (adjusted cost) for each session when there is no

 insurance coverage or until insurance pays (if claims are submitted for me).

\_\_\_\_\_\_\_\_\_\_\_ is the charge for missed appointments.

The above is based upon available knowledge and may be subject to change following discussion with your therapist. If you have any questions about fees, billing procedures or insurance reimbursement, please discuss them with your therapist.

If your therapist is billing your insurance company for services on your behalf, your signature below grants authorization to (A) furnish information concerning your diagnosis and treatments to your insurance carrier and (B) request your carrier to direct payment to the therapist.

**I have read, understand and agree to these policies.**

**Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**