Responsibility For Account
Self Pay Agreement

Client Name: _____ DOB: _____

Therapist: _____ Date: _____

Client Agreement, Authorization, Consent and Release

1. It is agreed that I am to be billed for all services provided by Minnesota Psychological Resources (MPR). I understand that I will pay the full agreed upon fee as listed below in the Fee Agreement section for the services provided. It is also agreed that I will make the payments at the time of the therapy session unless I have pre-arranged with MPR for a Third Party Payor to be billed for my services.
2. I agree to pay for all charges as listed below in the Fee Agreement section.
3. I understand that MPR will charge interest on unpaid balances 30 days after the date of service and I accept responsibility to pay interest charges.
4. I understand that psychological testing fees involve an additional charge and are not included in the charge for the therapy sessions.
5. I understand that clinic appointments must be cancelled at least one business day and 24 hours prior to the scheduled appointment time to avoid a late cancellation charge.
6. I understand that in the event that MPR has been unable to collect payment for services, MPR has the right and will turn my account over to a collection agency.
7. I understand that there is a $20 charge for NSF checks or any other checks that are returned to MPR.

Release of Records for Mental Health Care as Required by Law:

____ INITIAL TO INDICATE UNDERSTANDING: a copy of my records may be sent

- To health care providers directly involved with my care when I have provided my written permission.
- To State, Federal and accrediting bodies for required reporting and/or surveys for compliance.

NOTE: Records are not automatically sent to your referring physician. They must be requested.

Fee Agreement *(Fee to be determined by clinician and discussed with client)*

I agree to pay Minnesota Psychological Resources, at the time of each counseling or testing session, the sum of:

1. $_____ for the initial intake session(s)
2. $_____ for each individual psychotherapy session
3. $_____ for each group therapy session
4. $_____ Other

☐ MPR has received written notification from a Third Party Payor agreeing to pay_____ of the above listed fees for services and the client is responsible to pay_____ at each session. Above named client understands that he/she is completely responsible for this account and accepts full financial responsibility for any and all charges in the event the Third Party Payor fails to make payment to MPR.

I recognize that I am ultimately responsible for all charges incurred for the services provided at MPR. By signing this form, I consent to authorize my medical or mental health provider to assess and treat me. I understand that my provider is available to explain the purpose of the treatment, and that I have the right to refuse the recommended treatment. I understand I have the right to revoke this consent, in writing, at any time except where MPR has already made disclosures in reliance on this consent.

_____ _____

Client Signature (If a minor, Parent/Guardian's signature)

_____ _____

MPR Representative Signature Date