



Private Pay Financial Contract

Client Name: _____ DOB: _____

I understand that I am currently a fee for service client, my fees are fully my responsibility.

If I currently have, or qualify for, health insurance, and elect not to use it, I agree to the following:

_____ (initial) I will not submit for reimbursement for any services.

_____ (initial) I will discuss with my therapist if I wish to switch to insurance.

_____ (initial) I understand that I am waiving my rights to utilize my insurance and am privately contracting with my therapist for services rendered.

_____ (initial) I understand that I cannot ask for my private pay sessions to be submitted to my insurance retro-actively.

If I do not currently have insurance, I agree that I will notify my therapist, immediately, if I qualify for insurance and wish to use it. No reimbursement forms or submission(s) for service(s) will be performed/completed until my insurance has been verified, and authorized, by my therapist.

My session fees are as follows:

Service	Fee	
Diagnostic Evaluation	\$ _____	_____ (initial)
Follow-up Sessions	\$ _____	_____ (initial)

I agree to: Weekly Biweekly Monthly Sessions

I also understand I am responsible for paying the full fee, as listed above, if I cancel within 24 hours of my scheduled session

Client (printed): _____

Client Signature: _____ Date: _____

Therapist (printed): _____

Therapist Signature: _____ Date: _____