CLIENT NAME_____ **RECORD #**_____

FEE AGREEMENT

PEACE OF MIND, INC.

Payment for services is due when services are provided. As a courtesy to our clients and families, we will bill your insurance company in accordance with information you provide to us. You are obligated to pay any deductible or co-pay required under your insurance plan, at the time of service. You remain legally responsible for all charges.

Charges are based on the type of service provided to you. You will be charged for all appointments. With sufficient notice, an appointment can generally be re-scheduled within one week.

Failure to give 24-hour notice of cancellation will result in a $50.00 charge, with exception given to Medicaid clients. Missing two consecutive appointments will result in administrative closing of the file. Missing three appointments will also result in closing.

If additional time or services (such as telephone consultations) are provided, a pro-rated fee will be charged at $1.00/minute. There will also be a $50.00 charge if your insurance company, another agency, or a third party requires a lengthy or complex report.

Court appearances are not covered by insurance and if you expect that it will be required, please speak to your therapist about the cost of appearances, as it will require a deposit of $250.00.

It is assumed that this financial relationship will continue as long as we provide services or until such time as you notify us that you wish to terminate treatment. Once treatment terminates, any balance not paid in full will be considered due. When an account becomes 60 days past due, professional collection may be utilized and/or legal action taken.

My signature below indicates that I have read and understand this fee policy. I agree to take responsibility for fees charged to my account.

_____ _____

Client/Parent/Legal Guardian Signature Date

_____ _____

Witness Signature Date

Co-payment/Deductible Amount and Number of Authorized Visits:

$_____