

SPENCE COUNSELING CENTER, P.C.

CLIENT AND INSURANCE FEE AGREEMENT

Client Name: _____

Insurance Company: _____

Therapist Name: _____

Therapist – In or Out of Network: _____

Does Client Have Covered Insurance Benefits? _____

Is an Authorization for Services Required? _____

What is Your Deductible? _____ Has it Been Met Yet? _____

What is Your Co-Pay for Each Visit? _____

Do You Have a Financial Hardship? _____ If Yes, Indicate Below:

<i>What is Your Agreed Fee per Session Amount?</i>	
SCC Full Fee Evaluation <u>\$175 OR</u> _____	SCC Full Fee Individual <u>\$115 OR</u> _____
SCC Full Fee Family <u>\$145 OR</u> _____	SCC Full Fee Testing <u>\$60 OR</u> _____

NOTE: Your policy may have some exclusions and/or restrictions of services, and may be subject to deductibles and co-insurance. Benefits are determined when services are billed to your insurance company. **You will be responsible for services not covered or paid.**

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. YOU WILL BE RESPONSIBLE FOR PAYMENT AND BILLED FOR MISSED APPOINTMENTS OR CANCELLATIONS NOT MADE WITHIN 24 HOURS.

My signature below demonstrates that I have read, understand, and agree to the above.

Client, Guardian, or Policy Holder Signature

Date

Client, Guardian, or Policy Holder Signature

Date

Therapist Signature

Date