



Insurance/Fee Agreement Form

Client Name: _____ DOB: _____

Payment: (fee arrangement to be completed at time of first appointment)

Insurance Company: _____

Group or Identification #: _____

Phone # to verify benefits: _____

Fee Agreement: _____

Private pay or Co-payment for session is due at time of session unless previous arrangements have been made. Cancellation of appointment requires a 24hr notice in advance. Cancellations within 24 hours of session will require payment of \$60.00 fee for a missed session. My signature below confirms my understanding and acknowledgement of this cancellation policy. I also acknowledge that by signing this form I accept financial responsibility for any fees or balances not paid by my insurance or Medicaid.

Client Signature: _____ Date: _____
 (Signature of guardian)

Therapist Signature: _____ Date: _____