RASMUSSEN
COUNSELING

Insurance/Fee Agreement Form

Client Name:_____ DOB:_____

Payment: (fees to be paid and form completed at time of first appointment)

Insurance Company: _____

Identification #:_____Group # _____

Phone # to verify benefits:_____

Private pay or Co-payment or Deductible Payment 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 $100.00 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:_____