FINANCIAL AGREEMENT

The responsible party is the person who is ultimately responsible for payment for therapeutic services. By signing this agreement, you are indicating that you are the responsible party and that you agree with the following:

- Payment for services is expected at the time of your visit. Payment or co-payment for services if due at the beginning of the session.
- Appointments must be cancelled at least 48 hours in advance to avoid incurring a charge. The 48 hours are only within business hours and do not include weekends or holidays.
- The fee for late cancellations or failed appointments if equal to the charge for a full session. Insurance will not pay for late cancellations or failed appointments. In such an event, you are responsible for the entire fee for that service and not just your co-payment. The fee for a late cancellation or failed appointment when you have insurance therefore includes the portion typically paid by your insurance for a session and your co-payment.
- There will be a $25.00 service fee on all returned checks.
- You will be responsible for any charges incurred if legal or collections services are required for delinquent accounts.
- You agree to provide me with information about changes in your insurance coverage as soon as possible. If coverage terminates for any reason, you are responsible for all fees denied by your insurance due to lack of coverage.
- Services such as letters written on behalf of clients, written reports or assessments, appearance at meetings with schools or social workers are subject to a fee based on the time involved. These fees may not be covered by your insurance company.
- I will provide you with a statement at the end of therapy or at the end of the year, or quarterly (if requested) listing the dates of service, fees for service and amount of payment or co-payment paid. For individuals covered by PPO insurance plans that call for you to submit receipts for reimbursement, this will serve as statements for reimbusement.
- As per our agreement and/or my agreement with your insurance carrier, your fee or copayment for therapeutic service will be at the rate of _____ per 50 minute session.

I am the responsible party for therapeutic services and acknowledge and consent to this financial agreement.

_____Date _____
Responsible Party Signature

_____Date_____
Christine A. Volker, Ph.D.