

Thank you for choosing In The Garden Counseling for your counseling needs. Please read over our financial and missed appointment policy and initial beside each statement.

Counseling sessions are booked starting on the hour or half-hour. If you are late, the session begins at your appointment time. All fees for counseling sessions are due the date of service. This includes copays and deductibles if we are filing insurance for you. Please discuss any need to make payment arrangements with us. If your account becomes overdue, and no payment arrangements have been made, we have a contract with collection agency to collect payments more than 45 days past due.

_____ In The Garden Counseling maintains your credit card number on file in our secure electronic records database. This is used for your convenience to cover charges to your account. Your signature below indicated your permission for us to charge your account balance to the credit card on file. In this case you will be emailed a receipt.

_____ We file your insurance as a courtesy to you. You are responsible for the initial authorizations and for all fees that are applied to deductibles or non-covered services. You will never be charged for more than the contractual arrangement we have with your insurance company. Your signature below indicates your permission for us to release the necessary information to your insurance company to access your benefits.

_____ Unlike many doctor's offices, we reserve your appointment slot for you. We do not double and triple book appointment slots. Therefore, if you are unable to make your scheduled appointment, please cancel prior to 24 hours of your appointment time. Appointments canceled within 24 hours will be charged a late cancellation fee of \$50. This fee will be charged automatically to the card on file. We have a timestamped voicemail that allows you to leave a message during non-business hours; if we receive you message outside of the 24 hour window there will be no charge for cancelling.

_____ Appointments canceled within 2 hours of the scheduled time, or appointments that you do not arrive to, will be charged in full for the counseling session (\$95). Insurance will not reimburse for missed appointments or late cancellations. These will be automatically charged to the card on file. If you are running late, please call and let us know as your card will be charged 15 minutes after your scheduled appointment time for a no show.

_____ * OPTIONAL: If someone other than yourself is responsible for the financial aspect of your treatment, your signature below indicates your permission to release necessary appointment and financial information needed to ensure payment for account balances. If this is the case, please provide name and contact information for the responsible party:

Name: _____ Phone#: _____

Self-Pay Patients. Patients without insurance or with high deductibles are responsible for the cost of their care. Payment is expected at the time the service is rendered.

Methods of Payment. We accept cash, checks, and major credit cards.

I have read, understand, and agree to the above conditions.

Client Signature _____ **Date** _____