

Therapy House

700 Villa Street ~ Racine, WI 53403

Fax: (262)619-3263

PAYMENT AGREEMENT

Patient/Guardian Name: _____

Address: _____

Therapist's Fees:

Initial Evaluation	Per Hour	\$145.00
Psychotherapy	20-30 Minutes	\$90.00
Psychotherapy	45-50 Minutes	\$130.00
Legal Consultation	Per Hour	\$300.00

Missed Appointment Fees: \$65.00

By signing this agreement, you understand and agree to the following:

- Your health insurance policy is a contract between you and your insurance company. Your provider will submit claims to your primary insurance company as a service to you. Your provider does not submit claims to secondary insurance companies. This in no way relieves you of your responsibility for payment. **All claims that remain unpaid by your primary insurance company after 60 days will be billed to you for payment in full.**
- All charges not covered by your insurance company including co-pays and deductibles are due at the time of service.
- It is your responsibility to notify your provider immediately if your insurance coverage changes.
- Mental health benefits are subject to the terms and limitations of your insurance plan. It is your responsibility to know and understand these benefits as specified in your insurance plan, including eligibility, deductibles, and co-payments.
- A \$65 fee may be charged for missed appointments unless the appointment is cancelled at least 24 hours in advance. Insurance carriers will not pay this fee; therefore you are responsible for payment. This fee must be paid **before** another appointment will be scheduled.
- A \$30 service charge will be assessed for any check returned "insufficient funds."

I authorize my insurance carrier to pay the proceeds of any benefits directly to my provider. I authorize the release of medical information necessary to process all claims.

Patient/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____