Payment Acknowledgement Agreement

Patient Name: _____ Date:_____

Please read the following statements and initial below:

Initial ____ I understand and agree that my co-payment, co-insurance and deductibles are due and payable at the time of service. I understand that charges not covered by my insurance company as well as applicable co-payments and deductibles are my responsibility and will be subject to the therapists self-pay amount of $_____. I understand that co-payment and deductible amounts may change depending on my mental health benefits within my insurance policy.

Initial ____ I understand that any unpaid services will be considered delinquent and will be sent to a collection agency.

Initial ____ I understand and agree that I will be charged a $50.00 cancellation fee if I cancel my appointment with less than a **24 hour notice**. (Unless due to illness or emergency)

Initial ____ I understand and agree to the $3 fee when using a credit or debit card other than medical cards to pay for any and all services. Cash and check are no charge. There will be a $20+ fee for any bounced checks.

By signing below, I understand and agree to the above statements. *I authorize my insurance benefits to be paid directly to Hope for a Better Tomorrow.*

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

Administrative use only

By signing below, I, administration, have gone through the above statements with the client or the guardian of the client, in person.

_____ _____

Administrative Signature Date