Compassion Clinic THERAPY SERVICES **By signing the online form from the TherapyNotes Portal, you agree to all of the following as if to initial and completely fill out this document. The identifying information is taken from your previously filled out "Client Information" form.

Compassion Clinic: Therapy Services
Financial Contract Policy

Client Name: _____
Client Date of Birth:_____ ____

Client Responsibility (Please Initial/Check the Following):

_____**General Information**

Note that services will be provided at a rate of $200.00 per 38-53 minute session; and add or subtract $66.00 per 15 minute increment (i.e. under 38 minutes or over 53 minutes). By initializing this, you agree to have the full amount billed at time of service. You can choose to fill out the payment plan and/or the sliding scale fee application, and note that the agreed upon payment is due at the time of service. If you do have a payment plan, the remaining balance not paid at time of service will be added to your balance (i.e. you will pay your bill slowly over time, including after your therapy services are completed). If we agree on another rate per the sliding scale fee application, that will be your fee until otherwise discussed. At your convenience, Compassion Clinic: Therapy Services will hold your credit card information on a secure platform and will charge you the day of the appointment.

If you ask for work that requires more than 15 minutes of professional service (which, including ethically mandated documentation, will be most requests), you will be charged $66.00 for these extra services (per 15 minute increment as seen above). This includes consultation with other medical professionals, documentation creation, or extra client contact services that are outside the usual normal therapy services (i.e. crisis contact or any legal proceedings). Thus, it is recommended that we spend normal therapy time on such requests instead of asking for additional professional services outside the therapy session. These services are usually not covered by insurance.

If there is an outstanding balance from the previous set of therapy services, Compassion Clinic: Therapy Services requires payment prior to initiating new services. If you are up to date on your payment plan, continuation of services will occur without this barrier. If no payment occurs within 60 days, your balance may be transitioned to a collection agency, which may reduce your credit score.

Here at Compassion Clinic: Therapy Services, we do accept some insurance companies. It is the client's responsibility to know their own deductibles and copays; you will be notified in sessions how much is owed once insurance processes the claims. Any due amount after insurance processes the claims will be automatically deducted after how much is owed is attempted to be discussed, unless you opt into a payment plan. However, if you choose not to use insurance, you can submit the receipts from your payments of services to your insurance company for retroactive billing. Please consult your health insurance in the specific process on how to accomplish this, as insurance companies differ in their preferred process. Another note, please keep your receipts as you may be able to have tax benefits on your healthcare costs.

_____**Cancelation Fee $200**

Compassion Clinic: Therapy Services requires a 24 hour notice when canceling an appointment. This will allow us to offer the time to others. Note that the credit card on file will be automatically charged with the late cancel/no show fee if no emergency situation is explained before the cancellation. If a client is late to the appointment, without an emergency cause, the full charge for the normal 45 minute session will be charged; if the therapist is late, the client will be charged to the nearest 15 minute interval. Note that the cancellation fee will be the same as the sliding scale fee that we agreed upon.

At the discretion of Compassion Clinic: Therapy Services, your services may be discontinued due to excessive failed appointments or late cancellations or no payment is received within 30 days.

_____**Interns**

I am aware that Compassion Clinic: Therapy Services provides internship opportunities to mental health trainees who may be present or conduct all or part of sessions as part of their education. All fees and billing do remain the same when interns are present. You can object to interns at any point within your treatment. You have the right to ask for interns to not be present.

Authorization to Release Information

I, _____(client/legal guardian if client is under 18), hereby authorize Compassion Clinic: Therapy Services to release all information necessary to secure payment for services rendered and to mail and/or email payment statements. I understand that my records are protected by the Data Privacy regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations, and that I may revoke the consent at any time. I understand that this consent will automatically expire without my express revocation upon receipt of all payments due. I have the right to receive a copy or review information to be disclosed if requested.

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Responsible Party Signature Date