TREATMENT AGREEMENT

I agree to the following by signing below that:

1. I authorize Bonnie K. Shinhearl, LLC to file insurance claims on my behalf and to release treatment information necessary to process claims.
2. My treatment is solely with my clinician and not with any other clinician/provider in this practice or with an insurance company.
3. I have received a copy of the privacy rights and authorize treatment.
4. **Payment fees are your responsibility when insurance does not cover visits for the following reasons:**
    - **a.** Pre-authorization has not been obtained
    - **b.** Incorrect/inadequate information about self or insurance company was provided
    - **c.** Services that are not covered by my insurance, i.e. report writing, record fees, phone calls.
    - **d.** Deductibles have not been met.
    - **e.** I will confirm that my insurance covers services with my therapist. I may need to obtain an authorization from the insurance company
    - **f.** **24-hour notice is required for appointment cancellation to avoid a late fee and for missed sessions. This fee is not covered by insurance and is the guarantor's responsibility. Fees for missed appointments is $30.00**

FINANCIAL POLICY

Co-payments: To be paid prior to sessions. Cash, check, HAS, Credit Card

Letters: Written letters will have a minimum fee of $15.00. Case conceptualization/narrative reports will have a fee range of $50.00 to $100.00. Payment is to be made before the letter is written or sent to the recipient. This is not covered by your insurance. **COURT PER DIEM FEE: $600.00**

Telephone Contact: Phone calls with your therapist may incur a charge. This is not covered by your insurance.

Late Cancellations/No-Show Charge: $30.00 late fee for missed/late cancelled appointments. This is not covered by your insurance.

PLEASE INITIAL AND SIGN BELOW

_____I have read and understand and agree to this treatment agreement

PRINT NAME_____

SIGNATURE_____DATE_____