Integrative Health & Wellness Inc.

Payment Contract for Services

Client Name _____ Date _____/_____/_____

- A therapy hour is 45-50 minutes. $175 per session is payable at the start of each therapy hour, unless other arrangements have been made. Payment may be made with cash or credit card. No checks will be accepted.
- A credit card will be on file and charged for any outstanding balances at the end of each business day. This includes session fees, missed appointments, insurance copays and patient responsibilities. A convenience fee of $5 will be applied for each credit card transaction.
- A discount of $25 per session applies if cash is paid in full at the time of service.
- The client is fully and directly responsible to Integrative Health & Wellness Inc. for the payment of services rendered.
- Insurance coverage differs, so please check with your insurance company to determine the requirements for mental health coverage.
- If payment becomes a problem, you are encouraged to discuss this directly with your therapist to consider other alternatives.
- If fees change during the course of treatment, you will be given adequate notice of these changes.
- **You will be charged the full session fee of $175 for missed appointments or appointments cancelled with less than a 24-hour notice** (except in cases of illness, emergency or severe weather).
- Fees for telephone contacts or to prepare reports (for court, insurance companies or other entities) will be pro-rated, based on the standard hourly rate.
- Balances 30 days or more overdue will be assessed a late fee of $25 at the end of each monthly billing cycle.

Card information

Card Holder's Name _____

Last 4 Digits of the Card Number ___ ___ ___ ___ Card Type: _____Visa / Master Card / any other type_____

Valid Thru __MM__ / __YYYY_____ Billing Zip Code _____ CVC _____

I understand my responsibility for payment of fees. Please select one of the following payments options:

Initials I am registering as a **private pay client** and understand payment is due prior to services.
Waiver of Insurance Billing: I understand by receiving a cash payment discount, Integrative Health & Wellness Inc. will not bill insurance for services provided under this arrangement. No forms will be produced now, or in the future, for insurance billing purposes**. I agree to waive insurance billing by Integrative Health & Wellness Inc.**

OR

Initials I authorize Integrative Health & Wellness Inc. to provide information to my insurance carrier(s) concerning any services rendered to me or any member of my family. I understand it is my responsibility as the client to know and understand my insurance coverage/benefits. It is my responsibility to call my insurance company to verify services before services are rendered. If insurance does not pay for services received, I understand I am financially responsible to pay for these services.

I have been given a copy of the current fee policy and have been given the opportunity to discuss my financial situation with my therapist. I understand I will be responsible for all fees as indicated and as outlined on this payment contract. I authorize Integrative Health and Wellness to charge the balance due to the credit card on file.

_____ Date ____/ _____/ ____
Signature of Client/Legal Guardian

_____ Date ____/ _____/ ____
Witness

CARD TYPE

CARD NUMBER

EXPIRATION DATE

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CARD HOLDER NAME

CVC

BILLING ZIPCODE