Linda Esposito, LCSW
www.southpasadenatherapist.net
(626) 710-6578

Financial Agreement

Fees:

Individual/Family Psychotherapy, 50-minutes	$150.00

Responsibility for Payment
Payment for all fees is due and payable at the time services are rendered. In the case of minors, payment is the responsibility of the parent who consents to service.

Insurance
I am an out of network provider for most PPO insurance companies. Please clarify your mental health benefits with your carrier before incurring the cost of services. Regardless of your insurance status, you are ultimately responsible for full payment of the professional services from the date rendered.

If you pay me directly, I can provide you with an itemized statement that you can submit to your company to obtain reimbursement. If I bill your carrier for you, you hereby authorize payment of benefits to your provider for services rendered.

Release of Information to Third-Party Payors
Disclosure of medical information regarding the conditions being treated and the services being provided are generally required by insurance companies or other third-party payors for billing and for quality assurance purposes. Client or responsible person hereby authorizes release of this information as requested by third-party payors for this purpose. While insurance companies generally assure clients that no information will be released to your employer or other third parties, once information leaves this office, I cannot guarantee its security.

Cancellations, Emergencies, and No-Shows
If you do not appear for your scheduled appointment time, you will be charged the full amount of the appointment. If you provide 24 hours prior notice of your appointment time, there will be no charge for the cancellation.

Checks returned by the bank are subject to a service charge of $25.00.

I accept cash and personal check. Credit cards can be used to pay for full sessions.

I have read, understood, and agreed to the policies stated above. I have clarified any questions before signing this consent.

_____	_____
Client signature	Parent/guardian signature
_____	_____
Psychotherapist	Date