Client Financial Responsibility Form

Thank you for choosing The Hope Center for Healing. I am committed to providing you with the highest quality of care. Please take a few minutes to read and sign this form in acknowledgement of your financial responsibility.

I, _____ agree to pay for psychotherapy services and other clinical services according to the fee agreement between the therapist and the client.

I understand the following terms apply to this agreement:

Payment will be made as follows ; (check one):

_____ At the time of service

_____ Other (specify): _____

- The fee for psychotherapy, psychological testing and interpretation, consultation, letter or report writing or other clinical services is $200 per 50 minute session unless otherwise specified.
- Clients are ultimately responsible for all treatment and care.
- It is your responsibility to inform the therapist as soon as you know if there are changes in your ability or willingness to pay.
- Services will be terminated if timely payment is not made as agreed to by this consent.
- Consent to assume financial responsibility for these services does not entitle the third-party payer access to confidential information unless otherwise agreed in writing by the above named client.
- Clients may incur, or assume responsibility for additional charges if applicable, these charges include:
    - Return of Check Fee
    - Charge for Cancellations within 48 hours of your scheduled session.

Signature of Client: _____ Date: _____