BODY-BASED PSYCHOTHERAPY OF METRO DETROIT, PLLC

NAME:_____ DATE OF BIRTH:_____

PATIENT FEES AND PAYMENT AGREEMENT

This provider will bill usual and customary fees for standard services offered.

Additional services not covered by insurance companies:

LATE CANCEL OR NO-SHOW FEE	Session Fee (amount of insurance reimbursement + co-pay or self-pay fee)
Letter writing or form completion	$100.00/hour
Record requests	$1.00/page
Returned check fee	$35.00

I understand payment for services is due at the time services are rendered.

I understand any deductibles and co-pays are my responsibility and due at the time of service. I understand any deductible or co-pay applicable to my policy is best explained by my insurance carrier.

I understand it is my responsibility to keep my scheduled appointments or to notify Body-based Psychotherapy of Metro Detroit, PLLC twenty-four (24) hours prior to my scheduled appointment if I need to cancel. If I fail to do so, I will be charged a no-show fee (see above). This fee is due at my next scheduled appointment and cannot be billed to my insurance carrier.

I understand that Body-based Psychotherapy of Metro Detroit, PLLC reserves the right to use an outside collection agency as a means of collecting an outstanding balance if my account remains unpaid or if any payment arrangements are not kept. I understand that if my account goes to collections, I will be assessed the collection fees charged by the collection agency.

Fees are subject to change, and notice will be provided if possible.

PRIVATE PAY

For patients not utilizing insurance, usual and customary fees of Body-based Psychotherapy of Metro Detroit, PLLC apply unless a different rate is listed below.

Service Provided _____ $_____

I HAVE READ, UNDERSTAND, AND AGREE WITH THE FINANCIAL CONDITIONS DESCRIBED ABOVE.

_____

Patient/Parent/Guardian Signature Date

_____

Witness Signature Date