SAMSKARA HEALING

PSYCHOTHERAPY & YOGA OFFERINGS

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FINANCIAL AGREEMENT

Welcome to Samskara Healing. This financial agreement contains information for you on the financial policies and procedures for psychotherapy.

Please read this financial agreement carefully and ask any questions you may have. You will be asked to sign this agreement, indicating that you have read it, and that you understand and agree to the policies and procedures outlined.

1. INITIAL APPOINTMENT

   A. During your initial appointment, you will be asked to put a valid credit card number on file. This policy gives us consent to charge you if you fail to give 24 hours advance notice when canceling an appointment.

   B. Your therapist will discuss with you how he or she handles emergency situations in regards to charging your credit card.

2. ATTENDANCE AT APPOINTMENTS

   A. If you are unable to keep a scheduled appointment, please notify your therapist at least twenty-four **(24) hours** in advance

   B. Because your appointment time is held exclusively for you, **there will be a charge of $75.00 for any appointments missed or canceled with less than 24 hours notice. Insurance does not cover this fee.** We would appreciate your call as soon as possible

3. FEES AND PAYMENT

   A. My fee for private pay clients is $120 for a 60-minute session and $90 for a 45-minute session. However, your fee may be a contracted rate with your managed care company. Please check with your insurance company as to your portion of the fee (i.e. deductibles, co-payments, percentage covered)

B. Your co-pay or fee is payable at the ***beginning*** of each session. I accept cash, checks (made payable to Samskara Healing), or master card and visa. There will be a $25 charge for any returned check

C. All other professional services, such as requests for letters, filling out of forms, providing copies, extended phone or in person contacts with other professionals, preparation of reports, etc. are also subject to charges at a prorated basis.

I have read and understand the information regarding fees and payment. I understand and agree to this payment contract. I understand that I am responsible for my fee and that fees are due at the time of service. Please be advised that if a balance accumulates on your account and no effort is made on your part to pay the balance in a timely manner, I reserve the right to turn your account over to a collection agency and terminate services/treatment immediately.

____ I agree to pay _____ per counseling session

My Valid credit card information is:

Credit Card: VISA MASTERCARD AM.EX. DISCOVER

Number:_____

Expiration Date: _____ Billing zip code:_____

Client(s) Name:_____
(Please Print)
_____

Signature of Client(s) _____

_____

Signature of Therapist _____

Date: _____