Eugenia Salomon, MA, MFT

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PAYMENT FOR SERVICE:

Clients are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payments. I reserve the right to periodically adjust the fee.

My current fee is 140- for both initial intake session and for regular fifty (50) minute sessions.

CANCELLATION:

Since scheduling of an appointment involves the reservation of time specifically for you, the minimum of 48 hours is required for rescheduling or cancellation of an appointment. The full per session fee ($140-) will be charged for missed sessions without such notification. If you are paying a reduced fee then you will be expected to pay that same fee for any missed sessions. Clients billing sessions through insurance will be expected to pay a $50 fee for missed sessions.

CONFIDENTIALITY:

All information disclosed within sessions is confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: where there is reasonable suspicion of child or elder abuse; where there is a reasonable suspicion that the client presents a danger of violence to others or where the client is likely to harm him or herself unless protective measures are taken. Disclosure may also be required pursuant to legal proceedings.

CASH PAYMENT AGREEMENT:

I understand that I am responsible for all fees incurred.

I understand that Cash Fees are due at the time of service.

I agree to one of the following:

_____ I agree to pay the above listed service fees

or

_____ I have a financial hardship and have made an agreement with my therapist that I will pay a sliding scale reduced fee of _____.

INSURANCE AGREEMENT:

If I choose to use my insurance, I understand that diagnosis and treatment information will be shared with my insurance company for billing and treatment authorization.

I understand that I remain responsible for co-pay, coinsurance and deductible amounts. All co-pays are due at time of session.

I must notify Eugenia Salomon of insurance changes and/or discontinuation of coverage.

I remain responsible for all fees refused or unauthorized by my insurance plan.

Primary Insurance Company:	ID#:	Group Name or #:
Primary Insured Person:	Name:	Date of Birth:

Secondary Insurance Company:	ID#:	Group Name or #:
Primary Insured Person:	Name:	Date of Birth:

I have read and understand these policies.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Parent/Guardian: _____ Date: _____