FINANCIAL AGGREEMENT ADDENDUM

I have agreed to pay privately for my therapy.

The agreed upon charge is $ _____ per session.

Paperwork or other requests will be a separate cost if not done during the allotted time.

Additionally, I acknowledge that my insurance will not reimburse me for my decision to see my clinician privately. Tri-County Therapy & Consulting will not bill my insurance unless agreed upon in writing.

**If you are unable to keep an appointment, we must be notified at least 24 hours in advance. Failure to do so will result in a missed appointment charge of $50.00. After 2 missed appointments you will be required to pay in full prior to your next scheduled appointment OR your account and subsequent services will be discontinued at the provider's discretion.

**If a phone session is ever needed outside the regularly scheduled sessions, there will be a $20 charge for the first 30 min. and $15 for every 15 minutes following.

Please sign indicating that you have read and agree to the above office policies. Thank You.

Date _____ Signature _____