GROWTH AND HEALING
WELLNESS CENTER, LLC

CONSENT FOR TREATMENT and FEE AGREEMENT

ASSIGNMENT OF MEDICAL BENEFITS: ___YES ___NO
Your Deductible, if any: _____ Amount Met:_____

Your Payment Schedule:
$_____per session for_____sessions.
$_____per session for_____sessions.

Appointments are made on a regular basis and your time is held for you. Therefore**, at least 24-hour advance notice is needed. In the event you are unable to keep your appointment, and do not provide at least 24 hour notice, you will be charged a full session fee ($150/session or the amount your insurance company normally provides + copay**). Please note that your insurance company does not pay for missed appointments or cancellations.

Payment is due at the time the service is rendered. Future appointments will not be scheduled if your account is past due. If you accrue a balance past 60 days, you will be responsible for any attorney fees incurred in collection.

By signing this form, you are consenting to treatment at Growth and Healing Wellness Center, LLC. In doing so, you are agreeing to the terms of this contract.

If your insurance is cancelled or benefits change for any reason, you are responsible for notifying the therapist and the billing department immediately. If you do not notify us of any changes in your insurance, you may be responsible for any balance incurred in treatment that your insurance did not cover.

ACCEPTED AND AGREED BY:

Client, Parent, or Legal Guardian: _____

Dated: _____

Child or Spouse: _____

Dated: _____