|  |  |  |  |
| --- | --- | --- | --- |
| **Service Fees** | **Intake** | **Ongoing** | **Group** |
|  | $150 | $145 | $40 |

Payments must be made when services are rendered, at the time of the session.

You must cancel appointments 24 hours in advance or you will be charged a $50 fee.

Non-payment for two consecutive sessions will require the negotiation of a payment plan and review of this Fee Contact

Services can be discontinued due to non-payment of balances over 60 days.

**INSURANCE**

* 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.
* I must notify PTR of insurance changes and/or discontinuation of coverage.
* I remain responsible for all fees refused or unauthorized by my insurance plan.

|  |  |  |
| --- | --- | --- |
| Primary Insurance Co: | ID | Group |
|  Primary Insured (If you are spouse or dependent | Name | DOB |
| Secondary Insurance Co | ID | Group |
|  Primary Insured (If you are spouse or dependent) | Name | DOB |

Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_