FINANCIAL AGREEMENT

ACCOUNT INFORMATION:

Responsible party: **Relationship to client:**

Occupation:

Home Address: **Phone: ( )**

Employer and Address:

Employer Phone: ( )

E-Mail: _____

OFFICE BILLING POLICY:

1. I understand that I am responsible for the full amount of my bill for services provided.

2. Clients must pay their account IN FULL at the time of service unless a payment plan is set up with our office manager.

3. I understand that all payment plan payments are due by the 10th of each month.

4. Our office accepts, Visa, Mastercard, Discover, American Express and personal checks.

FINANCIAL AGGREEMENT

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 Amani Healing Centers privately. Amani Healing Centers will not bill my insurance. Amani Healing will provide a receipt for mental health services for me to file a claim to my Healthcare Saving's Account (HAS) or for my Out of Network Benefits (OONB)

****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 $25.00. After 2 missed appointments you will be required to pay in full prior to your next scheduled appointment.**

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

X _____

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

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