**Fee Responsibility and Cancellation Policy**

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. I also understand that I am responsible for any charges incurred due to a missed appointment, without the required 24-hour notice. The first missed appointment charge is $75.00 with any additional missed appointments requiring a full session charge of $100.

**EAP Clients**: I acknowledge that I must complete the required number of sessions delineated by my plan before payment will be processed. If these appointments are not completed, I understand I will be personally liable for all charges. In order to utilize your Employee Assistance Benefits, subject to availability, you must receive an authorization number from your EAP provider with the number of approved sessions. This number must be received by our front office prior to any visits you would like covered by EAP.

Transitions Therapeutic Services, will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions. If your insurance fails to make a payment to Transitions Therapeutic Services, you are ultimately responsible for your fees. We accept insurance as a courtesy and on occasion insurance companies do not pay due to diagnosis or pre-existing conditions. We do not know these details prior to submitting claims to your insurance company. If you have a balance on your account, we will charge your credit card for the fees. You are also agreeing to have your insurance company make payment directly to Transitions Therapeutic Services of North Texas. Copays or session fees will be automatically charged to the credit card on file prior to your session. If you cancel within the 24 hours requirement, your account will be credited. Clinicians are not responsible for accepting payments. For any payments or insurance/billing questions, please contact our main office phone at 469-712-5481.

**COURT FEES**

If you require services for court, we recommend that you hire another mental health professional for that purpose. Should you subpoena a therapist from our practice as a **factual** case witness or involve her/him in court related processes, you agree to pay a retainer fee of $1400.00 that is due at the time a subpoena is served with an additional $200.00 for every hour of the therapist’s time involved, including but not limited to phone consultation with client and/or client’s attorney about court hearing, drive time, wait time, court testimony, and/or deposition, paper preparation, and any other legal matters. Fees incurred for these services will be charged to the client and not filed with your insurance company. You agree to waive Transitions Therapeutic Services involvement in any legal matters they deem not appropriate for their participation.

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have the right to discontinue or reuse treatment at any time. I understand that I am responsible; however, for any balance due prior to a decision to stop treatment.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CLIENT/GUARDIAN SIGNATURE DATE