Head & Heart Therapy
917 SW Oak St. Suite 303
Portland, OR 97205

Financial Agreement, Credit Card on File Agreement, and Fee Schedule

Rates

Charges for individual counseling are $155 for a fifty-minute session. These rates are subject to change with the changing market and clients will be notified of any changes in rates. Group therapy rates are generally $35 for each group session if you choose to not utilize insurance.

Insurance

Services may be covered in full or in part by your health insurance or employee benefit plan. Please check your coverage carefully by calling your insurance provider prior to setting up counseling. It is your responsibility to know your copay and deductible at your first session. By signing this form, clients agree to allow their therapist or billing agent associated with Head & Heart Therapy, to release information to their insurance provider to process claims. Clients also agree to pay any portion not covered by their insurance carrier.

Card on File

In providing us with your credit card information, you are giving Head & Heart Therapy permission to automatically charge your credit card on file for your (or any other patient (s) you have listed on this form) co-pay/s, outstanding balance/s, and/or services. Payment is due at the time of services rendered. When using a credit card on file, payments will be automatically billed the next business day.

Cancellation Policy

If you do not show up for your scheduled therapy appointment, and you have not notified us at least 48 hours in advance, you will be required to pay the full cost of the session. If you fail to attend your intake session you will be referred to a different counseling clinic, our time is very valuable as private practitioners. A $25 fee will be charged for checks returned due to insufficient funds.

If you understand and agree with the above, we ask that you sign this document as a statement of your understanding and agreement to comply with our financial and fee schedules. This document may be used along with your personal information to collect outstanding fees if not paid in a timely manner.

Thank you for valuing our services by agreeing with these terms.

Patient Signature　　　　Printed Name　　　　Date

Parent/Guardian Signature (if under 18)　　　　Printed Name　　　　Date