

FEE PAYMENT AGREEMENT

\$125.00.....50 – 60 minutes Initial Diagnostic Interview
\$100.00.....45 – 50 minutes Individual Psychotherapy
\$100.00.....45 – 50 minutes Couples Psychotherapy
\$100.00.....60 minutes Preparation of letters/reports

(We reserve the right to charge for preparing narrative reports requested by the client or by another agency)

CONSENT FOR TREATMENT / EVALUATION

I hereby authorize Cyndie Ford Purdy, LMHC, to administer treatment and/or evaluation services. Payment of fees and the insurance procedures have been explained to me. I agree to pay fees at the time services are rendered. Should it become necessary to refer this account to an attorney or collection agency, I agree to pay all reasonable collection costs.

Signature of Client or Parent or Guardian

Date

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to client: _____

Date of Birth: _____ Social Security #: _____

Do you have medical insurance? _____ Yes _____ No **If yes:**

Name of Primary Insurance Company: _____

Contract #: _____ Group #: _____

Subscriber Name and Address: _____

Subscriber #: _____ Subscriber's Date of Birth: _____

Please mark the programs you are covered under:

___ Medicare ___ Medicaid ___ Champus ___ ChampVa ___ Worker's Compensation

ID# for program you checked above: _____

(NOTE: This provider is unable to accept Medicare or Medicaid. The insurance companies listed above may not pay for certain services. Please discuss your coverage with the office manager or call the customer service department of your insurance carrier).

Is your condition related to employment (current or previous)? _____ Yes _____ No

ASSIGNMENT AND RELEASE OF INFORMATION

I hereby authorize Cyndie Ford Purdy, LMHC, to release to _____
(Name of Insurance Company)

all information about my diagnosis and/or documentation of treatment I received for the purpose of reimbursement. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I assign directly to Cyndie Ford Purdy, LMHC any and all medical benefits, otherwise payable to me, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature of Client or Parent or Guardian

Date