



INTERPERSONAL STRATEGIES
& CONSULTING

Client Fee Agreement Form

Client's Last Name	First Name	MI	Client's Date of Birth
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Is it okay to leave a message? Yes No	Is it okay to leave a message? Yes No	Is it okay to leave a message? Yes No	

Person Financially Responsible

Relationship to Client:			
Last Name	First Name	MI	Social Security #
Street Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	Date of Birth

Insurance Information (primary):

Name of Insurance Company: _____

Name of Insured: _____

Employer: _____

Group #: _____

Policy #: _____

Customer Service #: _____

Benefits (will be completed by therapist):

Number of sessions available per year: _____

Number of authorized sessions: _____

Authorizations active until: _____

Copay: _____

Deductible (if any): _____

Other information: _____

- Client is expected to pay fees for each session at the time of service.
- Client agrees to the payment of \$120 per session or as contracted by client's insurance (includes copay).
- It is expected that you will attend every session as scheduled. If for some reason you are unable to attend the scheduled session, you must notify therapist 24 hours in advance. If you fail to contact therapist 24 hours in advance, you may be assessed a fee of \$60 (insurance will not cover this cost to you).
- Attending sessions regularly is strongly recommended for desired success. Several missed sessions can be the basis for terminated services.
- All services will be charged on an hourly basis (sessions are 45 minutes, and 15 minutes for documentation).

I have completed the requested information completely and to the best of my knowledge. I have read, understand, and agree to assume responsibility to pay fees and the policies set forth above.

Client Signature _____ Date _____

Therapist Signature _____ Date _____