Vitman Counseling LLC

# Insurance/Financial Agreement

Client Name _____ Date of Birth _____

Primary Insured _____ Date of Birth _____

Street Address of Insured _____

City, State, Zip Code _____

Insured Person's Phone Number _____

Relationship to Insured ◯ Self ◯ Child ◯ Spouse/Partner ◯ Other: _____

Insurance Company _____ Phone _____

ID Number on Card _____ Group Number _____

Insured's Employer _____

Deductible _____ Has the Deductible been met this year? ◯ Yes ◯ No

Number of Sessions Allowed per Year _____ Copay Due at Each Session _____

Professional Fees: Initial session $230
50 min Couples session $280
50 min Individual session $200
Late Cancellation/No Show Fee $150
Other professional services $250 per hour (e.g. consultations with other professionals with your permission, preparations of records or treatment summaries, and time spent performing any other service you may request of me)

If you become involved in legal proceedings (e.g., divorce, custody dispute, insurance cases, etc.) please understand that this therapist will not provide evaluation or expert testimony. You should hire a different mental health professional for any evaluation or testimony you require. This position is based on two reasons: 1) the statement may be seen as biased in your favor because of the therapeutic relationship; and 2) the testimony might affect the therapeutic relationship.

If you chose to disregard this and still require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $600 per hour for preparation and attendance at any legal proceeding with $3000 retainer in advance.

Vitman Counseling LLC

## CLIENT/RESPONSIBLE PARTY FINANCIAL AGREEMENT STATEMENT

- I understand that my portion of the fee (copay) is due at time of service unless otherwise arranged in advance
- I understand that a no-show fee will be charged for appointments cancelled without 48-hours' notice.
- Because insurance does not pay for missed sessions, I will be responsible for the full fee.
- I understand that I am responsible for paying my deductible and any amounts not covered by insurance
- I understand that if, for any reason, my insurance company does not pay my fee, I am responsible for the entire amount.
- I understand that if I become involved in legal proceedings and require Spomenka Vitman, MA, LMHC participation in it, I am responsible for the entire amount of her expenses due to my legal proceedings.
- I authorize the release of information needed to verify and process insurance claims to Spomenka Vitman, MA, LMHC.

Client/Responsible Party Signature _____ Date _____