EASTSIDE MENTAL WELLNESS

ACCOUNT INFORMATION:

Responsible party:_____

Home Address:

_____

_____

Phone: (  )_____

E-Mail: _____

OFFICE BILLING POLICY:

1. Clients understand that they are responsible for the full amount of their bill for services provided.
2. Clients must pay their account IN FULL at the time of service.
3. Our office accepts, Visa, Mastercard, Discover, American Express, cash, and personal checks.

FINANCIAL AGREEMENT:

I have agreed to pay privately for my therapy.

The agreed upon charge is $160 per session. Paperwork (other than one invoice per month) or other requests will be a separate cost if not done during the allotted time. Additionally, I acknowledge that my insurance will not reimburse me for my decision to see EMW privately and that EMW will not bill my insurance.

_____ _____

Signature Date