Print Form

Connections Counseling Services

Financial Addendum
to the
Informed Consent and Agreement for Services

This Addendum to the Informed Consent and Agreement for Services contains important information about the financial arrangement between you and Connections Counseling Services, Inc. ("Connections"). This Addendum, together with the Informed Consent and Agreement for Services, constitute a contract ("Agreement") between you and Connections. Please read it carefully and, if you agree to the terms, please initial or sign where indicated.

PAYMENT: Your therapy will be billed at the rate of $150.00 for a 90-minute session, $100 for a 60-minute session. This may be changed from time to time by written agreement between us. Payment for sessions is due at the time of each session unless arrangements have been made for a second party to pay.

Initial _____

MISSED APPOINTMENTS AND LATENESS: Please notify your therapist during business hours at least two full business days in advance if you must miss an appointment. Business hours are Monday through Friday, 10:00 am to 6:00 pm Mountain Time. Our office is closed on weekends and holidays. This means that if you need to cancel a Monday appointment, you should notify our office by the previous Thursday before the same hour of your appointment on Monday. This should also be taken into consideration when leaving messages of cancellation on our voicemail during non–business hours. We do not listen to those messages until the next business day.

Appointments broken with less than 24 business hours' notice (not counting weekends and holidays) will be subject to the full session charge. (Genuine emergencies may be excepted at the therapist's discretion.) This policy is in place because we routinely have a waiting list of clients who are anxious to take empty spots but who need some advance warning to rearrange their schedules.

It is your responsibility to arrive or call on time for each appointment, regardless of traffic and weather. Your therapist will not make up time missed because of your lateness. Your therapist will, however, make up time missed because of his own lateness. We recognize that unexpected illnesses and legitimate emergencies occur and will be willing to work with you when those arise.

Initial _____

INSURANCE REIMBURSEMENT: We do not bill insurance companies for payment. However, we will provide you with a monthly "superbill," which is a statement that you can present to your insurance company for reimbursement. Since each insurance company has its own coverage policies, and since each individual presents a different set of symptoms and treatment needs, we cannot guarantee that your insurance carrier will cover all or any of your therapy.

Initial _____

AGREEMENT OF CLIENT: I understand this information and agree to be bound by the terms and conditions of this Financial Addendum.

Client's signature: _____
or parent/guardian *Typing your name here constitutes an electronic signature and is legally binding.*

Date: _____

SECOND PARTY AGREEMENT: Should a second party (a parent, church, or other benefactor) have full or partial financial responsibility in paying for your sessions, their signature(s) must be on the financial addendum *along with yours*. All payments by a parent must be made by credit card.

Signature(s) of individual(s)
responsible for payment
(if other than Client): _____

Relationship to Client: _____

Mailing Address: _____

_____

Email Address: _____

Phone Number: _____

Date: _____

CREDIT CARD PAYMENT AGREEMENT: By signing your name below, you authorize Connections to charge your credit card account for services rendered at the rate of $150.00 per 90 minute session or $100.00 per 60 minute session.

☐ VISA ☐ MasterCard ☐ Discover

Card No. _____ Exp Date: _____

Cardholder's name: _____

Cardholder's billing address:

_____

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