Art of Therapy Center
A holistic approach to therapy with families

Financial policy

Please note, your entire record including this form is stored on HIPAA compliant electronic server

Fee for Service Agreement

1. Every time I/child _____schedule an appointment with my therapist I understand that I am entering into a contract with Art of Therapy Center and for the professional time and services of my therapist.
2. I recognize that professional services include time and services for preparation for my scheduled session, the actual time in session, time spent outside of session with case review, case notes, confidential consultations with supervisors or professional colleagues as outlined above.
3. I understand my therapist's professional fees as outlined in our Agreement to Enter into Counseling Services for scheduled sessions.
4. I understand I am expected to arrive 30 minutes before your intake/evaluation appointment to be registered and check in. Please arrive 15 minutes early for all follow ups to ensure your appointment starts on time.
5. I understand I am expected to arrive before the appointment time for my intake/evaluation appointment or by no later than 10 after the appointment time for follow up appointments or my appointment will automatically be rescheduled.

No Show & Late Cancellation agreement

6. I understand that Art of Therapy Center has a cancellation policy requiring no less than 24 hours advance notice in order to be released from the contract for my therapist's time and services of preparation for my session.
7. I understand that I will be charged a LATE CANCELLATION fee of $25 if I fail to give at least 24 hour notice prior to cancelling my appointment. Not applicable for Medicaid.
8. I understand that I will be charged a NO-SHOW fee of $150 if I fail to show for my appointment. Not applicable for Medicaid.
9. I hereby authorize Art of Therapy Center to charge my Visa/ Master Card for any missed sessions or unpaid charges per this contract. I understand my credit card will be stored in an encrypted merchant services system for my protection.

2907 Rousseau Ct. Gastonia, NC 28054
117 West Marion St. Shelby, NC 28150

Art of Therapy Center
A holistic approach to therapy with families

Financial policy

10. I understand if there is an emergency situation that prohibits me from canceling within 24 hours I can discuss this with my therapist directly and request a waiver of this policy but I understand that Art of Therapy Center and my therapist are not bound to grant that waiver and may, by this contract, proceed with charging my credit card as agreed herein.
11. I understand if payment is not made before or during my scheduled session I am hereby authorizing Art of Therapy Center to charge my afore-listed credit card for services rendered.
12. I understand this agreement authorizes Art of Therapy Center to charge my credit card for services requested and rendered outside of the office such as email counseling, phone sessions, preparation of documents requested by me or any court related proceedings.
13. Please note that NC Medicaid Clients are subject to different legal policies due to the nature of our contract with them. If you are a client that has NC Medicaid, your financial policy will be discussed at your intake appointment.

Co-payment Agreement

14. I understand that I am responsible for knowing my co-payment amount and deductible amount.

    My co-payment amount per session is _____;

    My deductible amount per year is _____.

    Have you met your deductible for this year? ☐YES ☐ NO ☐UNSURE

    If no, how much more do you have to pay towards your deductible?_____

15. I understand that I will be charged a $10 service charge if I fail to make my payment and/or co-payment at the time of my appointment, unless otherwise discussed with therapist.
16. I understand that these charges are an out of pocket expense and that my insurance carrier will not cover these charges.
17. I understand that the therapy sessions will be scheduled for 60 minutes {Sessions can last anywhere from 20-60 minutes}. I understand that if I am late to the appointment, I will still have to end the session at the allotted time.

2907 Rousseau Ct. Gastonia, NC 28054
117 West Marion St. Shelby, NC 28150

Art of Therapy Center
A holistic approach to therapy with families

Financial policy

By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

_____
Signature of Responsible Party

_____
Name of Responsible Party

_____
Date

2907 Rousseau Ct. Gastonia, NC 28054
117 West Marion St. Shelby, NC 28150