AGREEMENT TO PAY

❑ I agree to pay for services that I receive at *Lorven Child and Family Development* (including individual, couples and family therapy, collateral contact and court appearances). I agree that it is my responsibility to inform *Lorven Child and Family Development* of any change that may affect my co-pay. This may include, but is not limited to, change in income, change in insurance coverage, etc. Failure to notify *Lorven Child and Family Development* of such changes may result in my fee reverting to the fees listed below.

Fee	Rate
Fee for Intake =	$150.00 per 60 mins.
Fee for Individual and Play Therapy =	$100.00 per 45 mins.
Fee for Individual and Play Therapy =	$120.00 per 60 mins.
Fee for Family Therapy with or without client =	$100.00 per 45 mins.
Collateral Contact =	$60.00 per 60 mins.
Court Appearance/Testimony =	$500.00 retainer fee & $150.00 per hour (min. 2 hours)

❑ I agree that I will pay per my insurance coverage = Deductible $_____________
Co-pay $__________ per session
Co-Insurance_______% per session

❑ I agree that I will pay $___________ per session (self-pay rate).

❑ **Authorization to Collect Insurance -** I authorize *Lorven Child and Family Development* to release only information necessary to process insurance claims on services provided by this company. I authorize this office to apply for benefits on my behalf for covered services rendered and request that payment from my insurance company be made directly to *Lorven Child and Family Development.* I understand that it is my responsibility to notify *Lorven Child and Family Development* of any change in my insurance coverage or benefits. I understand that I may be responsible for claims not paid by my insurance company as a result of such change.

❑ I agree that I will provide my therapist at least 24 hours' notice when I need to cancel my session. Less than 24 hours' notice of cancellation will result in a cancellation fee of $50.

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Signature of Client, Parent or Guardian Date

Client: Record No.: Date of Birth: