

Client Name: _____

Case Number: _____

Fee Agreement

In order to continue offering therapeutic services to you and others at Amy Kinner, LMSW, LLC, it is important that you keep all of your scheduled appointments. Your scheduled time is reserved exclusively for you. Therefore, we ask you to agree to the following.

I understand that if I cannot attend or will be late to any scheduled appointments, it is my responsibility to notify Amy Kinner, LMSW, LLC at least 24 hours in advance. If I fail to provide 24 hours advanced notice, I am responsible for a “no show/late cancel” fee in the full amount of the session fee, unless my absence is due to illness or an emergency.

I understand that I am responsible for a \$25 Non-Sufficient Funds bank fee for checks that do not clear.

I understand that through my insurance, I have an annual deductible of \$_____ and a co pay of \$_____/session.

In lieu of insurance, I understand that my fee for an intake assessment (1st session) is \$100, and that my fee for subsequent individual sessions will be \$_____, couple/family sessions will be \$_____, and group therapy sessions will be \$_____.

By my signature, I acknowledge my responsibility for the above fees whenever applicable. I understand that I must pay these fees when due before services can continue.

Client Signature

Date

Therapist Signature

Date