Full Circle Behavioral Health, PC.

FEE AGREEMENT

I_______________________________________agree to pay in full on the day of rendered services $120.00 per therapeutic/full session (45 minute session), or the amount allocated by my insurance company for myself, my child, or a minor of which I have legal guardianship of the name of ____________________________________________to Lori Little and/or Full Circle Behavioral Health, PC.

I_______________________________________further understand and agree to the following:

- I am solely responsible for payment of services for myself, my child, or any minors of which I have legal guardianship, regardless of insurance coverage.

2. Any account balance over 90 days past due may be referred to a collection agency.
3. Payment must be received in the form of a check, money order, or credit card.
4. Appointments must be canceled 24 hours prior to the scheduled appointment time or you will be charged the full amount of your appointment fee. This includes late cancellations and no shows to an appointment. The exception to this agreement is a documented medical emergency.
5. Payment for late cancellations of appointments or missed appointments are due in full by next scheduled appointment/session.
6. I agree to pay a $35 return check fee for each returned check.
7. I understand that if I am late for my appointment that my session will end at the designated appointment time and that I will be solely responsible to pay for the minutes that I was not present. I further understand that if I am more than 20 minutes late for my appointment, I will be solely responsible to pay for the entirety of my session and that my insurance is not responsible for these incurred charges.
8. I agree to pay my co-pay/deductible at the time of service and I understand that if I do not, it is required to be paid in full prior to my next appointment time.
9. I understand that I am responsible for knowing my insurance benefits and recognize Full Circle Behavioral Health does not check my benefits for me and is not responsible if my insurance does not cover the services.

Certification:

I have read the above information. I have had the opportunity to ask questions and understand and agree to the conditions and terms of this policy/agreement. I further understand the refusal to sign this document may be grounds for denial of services.

_________________________________________________ ____________________
Signature of patient/responsible party Date

_________________________________________________
Printed name of patient/responsible party

_________________________________________________ ____________________
Lori Little, MA LLP
Signature of Practioner Date