www.metta-counseling.com

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES
PAYMENT FOR SERVICES RENDERED

☐ Upon verification of your health plan/insurance coverage and policy limits, your insurance carrier will be billed for your treatment and your Therapist will be paid directly by the carrier. You will be responsible for any applicable deductibles and co - payments. If you are not eligible for insurance coverage at the time services are rendered, you will be responsible for the full payment. All payments are due at time of visit.

OR

☐ I, the undersigned, request that **Metta Counseling Services,,** provide professional services to me/or _____ as a client, and I agree to pay therapist's fee, based on Metta Counseling Services' Self Pay Fee Schedule provided.

If the client is a minor, I understand that while I have a right to general information on issues and progress, some information shared in this professional relationship will be held in confidence by the therapist and the minor child.

If, at any time, I am dissatisfied with services, I will fully discuss my views, reasons and plans with the therapist (and if the patient is a minor, with the patient named above).

I agree that this financial relationship will continue in effect with the above named company as long as these services are provided or until I inform the therapist, in person, by telephone or by certified mail of my desire to terminate services. I agree to pay for services rendered to "client" until such time that the therapeutic relationship is terminated.

I understand that I am responsible for charges for services provided by this therapist to this client, although other persons or insurance companies may make payments on this client's account.

Signature: _____ **Date: _____**

Printed Name: _____

Relationship to the patient: □ Self □ Other: _____

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