Personal Growth Concepts, Inc.

COUNSELING & RELATED SERVICES

FEE CONTRACT FOR CLINICAL SERVICES

For clinical services rendered by Personal Growth Concepts' (PGC) professional staff, I agree to pay:

$_____ Client fee (amount that I agree to pay at each session)

$_____ Insurance (I understand that this is the amount expected to be paid by my insurance or managed care company. I understand that any deductibles are my responsibility)

$_____ Adjusted, if applicable. I understand and agree that PGC will adjust this amount.

$_____ Total

I further understand that I am required to cancel any scheduled appointments by 5 p.m. the day preceding the appointment. I understand that I will be charged and I agree to pay $40.00 for canceling with less notice than required.

I also understand that I will be charged and I agree to pay $50.00 if I do not show up for an appointment. Insurance companies are not billed for late cancellations or no-shows.

Lastly, I agree to notify the PGC business office or my therapist of any changes in my insurance coverage. I understand that I am responsible for payment for services not covered by my insurance.

x I authorize use of this form on all my insurance submissions.
x I authorize release of information to all my Insurance & Managed Care Companies.
x I understand that I am responsible for my bill.
x I authorize Personal Growth Concepts, Inc. to act as my agent in helping me obtain payment from my Insurance Companies.
x I authorize payment direct to the provider, Personal Growth Concepts, Inc.
x I permit a copy of this authorization to be used in place of the original.

Name (print) _____

Client Signature _____ Date _____

Witness _____ Date_____

Feecontract.doc

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