**INSURANCE TREATMENT AND FEE AGREEMENT**

Please carefully read the following items. If you have any questions or do not understand what is being asked, do not sign this paper! Instead, discuss your concerns or confusion with your therapist. If you are comfortable signing this page, please return it to your clinician.

* I understand that by signing this document I am consenting to treatment with Dr. Sheela Reddy.
* A fee for service/copay, which may vary depending on the length and type of service provided, is \_\_\_\_\_\_\_\_\_\_\_\_ per hour. I understand that I will have to pay a $35.00 fee for any returned checks and interest charges (5% monthly) for any payments that are past due for over 30 days.
* I understand my rights, the billing arrangement, **cancellation policy (36 hours notice)** and insurance policy (out of network). If I do not cancel in time my insurance company will not cover the cost and I am responsible for the fees.
* I authorize the release of information necessary to process claims with my insurance provider.
* My therapist provides me with a safe office in her home. I agree to respect the safety of her office and not reveal the location to anyone without the explicit permission of my therapist. **If I, or anyone related to me, damages any property or possession of the office, I will be financially liable for these damages.**
* I have been informed of how to contact my therapist, and how to proceed in the case of an emergency when my therapist is not immediately available.
* I have been informed of laws regarding confidentiality and limits to confidentiality.
* I understand that my therapist may seek consultation from other professionals regarding my case and that information that might specifically identify me as a patient will be withheld during these consultations.
* I understand that my therapist may request that I sign a Release of Information permitting communication with the individual/organization I specify.
* I have received a complete copy of this Outpatient Services Contract as well as policies regarding the HIPAA Security Rule. I understand that I can also access these documents on the SPIRITherapy website at www.spirtitherapy.com

*Your signature below indicates that you have read and understand the information in this document and agree to abide by its terms during our professional relationship.*

Signature of Patient or Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_