# LIKEMIND

Mental Health & Wellness, Inc.

## FEE AGREEMENT AND CANCELLATION POLICY

I understand that by signing this document, I am agreeing to the following responsibilities regarding services at LIKEMIND Mental Health & Wellness, Inc.

FINANCIAL OBLIGATIONS: I understand that I have full financial responsibilities for any services rendered at LIKEMIND Mental Health & Wellness, Inc.

Payment for services must be made at the time of the service. I understand that if I do not make a payment of charges due at the time of a service, that the appointment will be cancelled and a late cancellation charge of $50.00 will be added to my account.

I understand that if LIKEMIND Mental Health & Wellness, Inc. incurs any charges associated with the collection of payment for services, those charges will be added to my account.

HEALTH INSURANCE: I understand that LIKEMIND Mental Health & Wellness, Inc. will bill my health insurance company as a courtesy. I am fully responsible for any copays or deductibles as dictated by my insurance plan. I understand that I am fully responsible for payment of services rendered in the event that my insurance company does not reimburse LIKEMIND Mental Health & Wellness, Inc. for services rendered.

CANCELLATION AND NO SHOW POLICY: I understand that appointments that are cancelled with less than 24 hours notice or that must be rescheduled due to late arrival will be charged a late cancellation fee of $50.00. I understand that appointments that are missed without notification will be charged a no-show fee of $75.00 ($300.00 in the case of a neuropsychological evaluation).

TERMINATION OF SERVICES: I understand that LIKEMIND Mental Health & Wellness, Inc. reserves the right to suspend treatment in the event that I do not fulfill my financial obligations. In such an event, LIKEMIND Mental Health & Wellness, Inc. will continue to provide services, for which I will be financially responsible, for a reasonable amount of time so that another treatment provider can be contacted and/or in the event of an emergency.

PAPER COPIES: I understand that there is a charge of $25.00 when a request is made for a copy of my patient chart, and that it may take several business days to complete the copy.

Patient Name: _____ DOB: _____

Responsible Party Name: _____

Responsible Party Signature: _____

Date: _____

Witness Signature: _____ Date: _____

Please save this form to your computer, and then click the submit button below. At the next screen, drag and drop your saved document onto the secure file transfer window.

**CLICK HERE TO SUBMIT**