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: _____________________

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