**FINANCIAL AGREEMENT & CONSENT FOR SERVICES PROVIDED BY VELLES COUNSELING SERVICES LLC**

**Update September 2023**

\_\_\_\_\_ (initial) I understand that I am responsible for the payment of this account regardless of insurance coverage; this may include a copayment and/or a deductible each session. I understand that I may be contacted by email or mail to have payment collected for services rendered. If I choose not to use my insurance, I will be responsible for the full fee.

\_\_\_\_\_ (initial) I agree that if I miss an appointment without notice I will be responsible for a fee of $125.

\_\_\_\_\_ (initial) I agree that if I miss an appointment and give less than 8-hour I will be responsible for a fee of $75 (except in unforeseeable circumstances, such as sickness, accident, death or similar circumstances).

\_\_\_\_\_ (initial) I understand and have read, or have had explained to me, any documents that bear my signature. I understand that I may receive a copy of any such document upon request. These may include the following:

* This Financial Agreement & Consent for Services
* My therapist’s disclosure statement
* My therapist’s fee scheduled
* Any others that apply to me and that I have signed

I, the undersigned, agree to receive, and compensate for, services through Velles Counseling Services LLC, as noted above.

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Name of Patient Signature Date

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***If patient under age 18*** Signature Date