Acclaim Behavioral Services, LLC

Fee Agreement and Cancellation Policy

By signing this document, I am willfully entering into a contract with Acclaim Behavioral Services, LLC regarding payment of fees for services rendered.

1. **FINANCIAL RESPONSIBILITY**:

I acknowledge full financial responsibility for services rendered by Acclaim Behavioral Services, LLC. Payment of these charges is collected at the start of each session. I understand that any charges incurred by Acclaim Behavioral Services, LLC associated with collection of payments (e.g., insufficient funds, collections costs, denial of insurance benefits) will be forwarded on to me.

2. **CANCELLATION / NO SHOW POLICY:**

As appointments that are cancelled with less than 24 hours notice typically cannot be filled with other patients, **any cancellation made with less than 24 hours notice or any appointment missed will result in your being charged for the appointment**. Rates are $50.00 for appointments cancelled with less than 24 hours notice and half the cost of the session fee for any appointment that is missed without notification (**minimum** charge of $50.00). These charges are not billable to any insurance company. Appointments cancelled due to inclement weather, patient or family illness or family death will not incur a charge.

3. **SERVICE TERMINATION:**

I understand that if I do not make payments for services, that Acclaim Behavioral Services, LLC reserves the right to suspend treatment, upon appropriate notice, and will assist in making a referral elsewhere. If treatment is to be terminated your therapist will treat you for a brief period of time until another provider is identified, and he or she will send copies of your record to your new provider upon receipt of your authorization to do so. Even if treatment is to be terminated or transferred elsewhere, in the event of an emergency your therapist will provide appropriate and necessary care.

I have read and fully understand and agree to the above fee agreement and cancellation policy.

Patient Name: _____ DOB: _____

Responsible Party's Name: _____

Responsible Party's Signature: _____ Date: _____

Responsible Party's Social Security #: _____

Witness Signature: _____ Date: _____