NANCY S. RICHARD, PH.D.
Clinical Psychologist

FEE AGREEMENT

Client: _____

Name of Responsible Party: _____

Name of Employer: _____

Insurance Information:

Insurance Plan Name: _____
Policy Group Number: _____ Insured's ID Number: _____
Mental Health Administrator: _____
Phone number to contact for Mental Health: _____
Address to send claims: _____
_____
_____

Insured's Date of Birth _____ Sex: male __ female __
Is there another health benefit plan? Yes __ No __

I, _____ agree to pay Dr. Nancy Richard $125.00 for each therapy session. I understand that if I miss my appointment or do not cancel within 24 hours, I will be billed at half the hourly rate. I also understand that insurance will not cover this fee. In case of emergency, I will inform Dr. Richard as soon as possible. I will be responsible to pay all deductibles and co-pays that apply.

Client: _____ Date: _____

Therapist: _____ Date: _____

I agree to release Protected Health Information about myself to my insurance company for the purpose of financial reimbursement of fees for counseling services. I have the right not to agree to release this information, and I understand that failure to release requested information could impact whether my insurance company will reimburse my counseling fees. I have the right to rescind this release by providing a written request.

Client: _____ Date: _____