Applied Therapies
And Wellness Center, S.C.

STATEMENT OF CONSENT/AGREEMENT FOR TREATMENT

****BILLING INFORMATION:**
Applied Therapies and Wellness Center, S.C. will bill any psychological evaluations or treatment services rendered through our agency to your insurance company. Practitioners in an outpatient mental health clinic generally do not receive a salary or hourly wage. They rely completely on timely payments from patients and insurance companies to cover their expenses. Applied Therapies & Wellness Center, S.C. will process all insurance claims and payments, and will send you a monthly statement of your account balance if applicable. Any insurance deductible and/or co-payment are your responsibility to pay by check or cash, and are due at the time of service. Any portion of your session fee that is not covered by your insurance is **your** responsibility and is due at the time of service. All personal checks must be made out to Applied Therapies & Wellness Center, S.C. If you have any billing or insurance questions you may contact our Billing Specialist at 414-302-1233. A $50.00 fee will be charged to your account for any returned checks made out to Applied Therapies & Wellness Center, S.C.

****Client initials _____ Date _____**

****CANCELLATIONS AND APPOINTMENT TIME CHANGES:**
At least 48 hours' notice must be given for all cancellations. This means that if you are scheduled for a 5 p.m. appointment on Thursday, you must call BEFORE 5 p.m. Tuesday to cancel the appointment. If you fail to provide at least 48 hours' notice for a therapy cancellation, you will be charged a $50 Cancellation Fee. If you fail to show up for your scheduled appointment, you will be charged a $50.00 No-Show Fee. Please note that insurance does not pay for cancellation or no-show fees and you will be expected to pay. For psychological testing services, there is a 1 late cancellation/no-show policy. If a 48 hour notice is not provided for canceling/rescheduling psychological testing appointment(s), Applied Therapies and Wellness Center, S.C. will not reschedule the appointment.

****Client initials _____ Date _____**

I, _____, have read and understood the Statement of Consent/Agreement for Treatment, Confidentiality and Patient Rights, Handling of Protected Health Information, Case Consultations with the clinic's Medical Personnel (Consulting Psychiatrist), Termination of Treatment, **Billing Information Fees, **Cancellations, and Emergencies which were provided to me and I consent to them.

_____ _____
Patient Signature Date

_____ _____
Responsible Party Signature Date

_____ _____
Witness Signature Date

***** BOTH sections for "Billing Information" and "Cancellations and Appointment Time Changes" need to be initialed and dated by client.***

This Agreement regarding Consent, Policies, Services, and Fees is good for 12 months from the date of signature on this form.