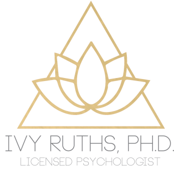


FINANCIAL RESPONSIBILITY CONTRACT

PROFESSIONAL FEES AND PAYMENT Our first meeting, or the initial evaluation, is billed at $295.00. All subsequent appointments, which are typically a 45-50 minute therapy-hour, are billed at $195.00. In addition to therapy appointments, this is the hourly rate for other services, including assessments, attendance at meetings with other professionals you have authorized, and telephone conversations lasting longer than 20 minutes. This fee is **due at the time of the session** unless we agree on another arrangement beforehand. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment (e.g., collection agency or small claims court). [If such legal action is necessary, its costs will be included in the claim.]

CANCELLATION POLICY Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice. Please note that many insurance policies do not cover broken appointment fees. Exceptions may be made if we both agree that you were unable to attend due to unforeseeable circumstances beyond your control.

INSURANCE REIMBURSEMENT In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. I am not contracted with any insurance networks. Should you decide to use insurance, you will be provided with the necessary documentation in order to submit claims directly to your insurance company. Furthermore, you (not your insurance company) are responsible for full payment of fees at the time of the session. If you have questions about your coverage, call your plan administrator. I will provide you with whatever information I can based on my experience.

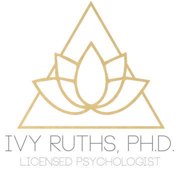
AGREEMENT AND SIGNATURE I herein acknowledge that the policies, guidelines and parameters outlined above may be amended or changed without prior notice, and that I will be notified of such changes in writing. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

______________________________________ _______________

Financial Guarantor Signature Date

______________________________________ _______________

Ivy Ruths, Ph.D. Date
Tx License # 36388



CREDIT CARD AUTHORIZATION FORM

I authorize Dr. Ivy Ruths, Ph.D. to keep my signature on file and to charge the below credit card(s) for the recurring charges incurred for ____, throughout the course of treatment.

Payor source:

Credit Card Type: ____________________________________ (All major credit cards accepted)

Credit Card No: _______________________________________

(3 or 4 digit code): ____________________________________

Expiration Date of Card: ____

Card Holder's Name: ____

Billing Address: ____

____

Weekly amount to charge: $195.00 per session beginning on date of ____________________.

____ _________________

Approval Signature Date