GROUP FEE AGREEMENT

A. Payment Plan – I agree that payments for group are due at the beginning of each month of group. Please initial each line:

_____I intend to pay in full for the month of group sessions at the beginning of each month. I understand that the fee for group is $75/session, $50 by check/card OR $45.00 by cash.

_____I understand that no show or late cancelled session will be charged to me at the full fee as described above.

_____I authorize that the monthly fee will be charged to me until I provide a 30 day notice of intent to leave the group.

Insurance Information (Only if you would like to bill your insurance)

Primary Insurance Carrier:_____Phone:_____

Claim Address:_____City:_____ Zip:_____

Name of Insured:_____ Relation to Client:_____

Insured ID:_____Group #:_____

Insured DOB:_____/_____/_____ Phone:_____Employer:_____

Insured's address:_____ City:_____ Zip:_____

Secondary Insurance Carrier:_____Phone:_____

Claim Address:_____City:_____ Zip:_____

Name of Insured:_____ Relation to Client:_____

Insured ID:_____Group #:_____

Insured DOB:_____/_____/_____ Phone:_____Employer:_____

Insured's address:_____ City:_____ Zip:_____

I hereby authorize the release of all medical records necessary to process an insurance claim. I hereby authorize my insurance carrier to make payments directly to Brad Larsen Sanchez, PsyD, Licensed Psychologist. I understand that I am financially responsible for all charges, regardless of insurance, unless otherwise written by Brad Larsen Sanchez, PsyD, Licensed Psychologist.

Sign Here

Name:_____ Signature:_____ Date:_____