Odyssey Counseling
Let us help you put your life back together

Payment Disclosure

_____ I understand that a scheduled appointment time is reserved specifically for me, and that it is part of my agreement to give 24 hours notice of cancellation or reschedule. I understand that cancelled/rescheduled sessions are not covered by my insurance or EAP (if applicable). Therefore, if I cancel/reschedule and it is less than 24 hours from the time of session, I will incur a fee of $50. The *only* exception is if the missed session is due to a critical emergency or other circumstances that are discussed with my therapist beforehand.

_____ I understand that three (3) or more "no show/missed" appointments in a 6 month period may result in discharge from Odyssey Counseling.

_____ I understand I am responsible for my incurred health expenses. I give Odyssey Counseling permision to bill my insurance carrier for services rendered. I understand that I am responsible for co-payments, co-insurance, and any non-covered services. I understand it is my responsibility to inform Odyssey Counseling of any updates or changes to billing or insurance.

_____ I understand that payment is due at the time of service. If I have an unpaid balance and have not made arrangements with the billing office, my outstanding balance will accrue late fees of $5 per day until the balance is paid off or until arrangements have been made. Services will not be provided by Odyssey Counseling until outstanding balances have been paid in full.

Your initials above and your signature below indicate that you have read this document and agree to its terms.

_____
Client Name (Print)

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

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