Clarissa I. Pearce, MS, LMHC
203 W. Holly St. #326
Bellingham, WA 98225

360.393.9015
clarissa.i.pearce@gmail.com

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

Client Name:________________________________

I, _________________________ agree to pay all fees and charges for evaluation and treatment for the person named above. If for any reason, I no longer agree to pay for evaluation and treatment, I will contact Clarissa to discuss the next steps.

If using insurance, I understand that estimates of coverage by insurance are only estimates and cannot be guaranteed until the claim is processed. I agree to pay all co-pays, co-insurance, and make payments toward the deductible as the Client's insurance plan stipulates.

I agree to pay all charges promptly unless credit arrangements have been agreed upon in advance.

I know that I can reference the form “Policies and Procedures” on Clarissa's Website clarissapearce.weebly.com for more detailed information about fees and other policies.

I have read the late cancellation and no-show policy. I understand that if the Client does not show or cancels with less than 24 hours of notice, charges will be added to the bill. The Client and I will determine together who will be responsible for paying these charges.

NOTICE: You are entitled to a copy of this agreement.

Signature:_____________________________________ Date:________________________

Printed name: __________________________________ Relationship: ________________

Client Signature:________________________________ Date:________________________

Bill to address: _________________________________

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Message Phone number: ________________________