



More MH Counseling
Make More Happen

Treatment Fee Agreement

Date: _____

Client information:

Name: _____
Age - Date of Birth: _____
Social Security #: _____
Driver's License #: _____
Gender: _____ Male _____ Female

Insurance: _____

Guardians:

Name: _____
Age - DOB: _____
Social Security #: _____
Driver's License #: _____
Gender: _____ Male _____ Female

Name: _____
Age - DOB: _____
Social Security #: _____
Driver's License #: _____
Gender: _____

Contact:

Home Address: _____
Phone: _____

Email: _____

Fees: Review Treatment Agreement Policy to review fees associated with missed/late fees.

Self-Pay (45min): _____

Co-Pay: _____

Phone Consultations: _____

Treatment Letters: _____

Consent

I _____, consent to treatment with More MH Counseling LLC. I agree to the fee's established above and I am fully and solely responsible for all fee's without insurance reimbursement. I agree that the credit card on file may be charged for missed appointment fees or additional fees assessed. I/we have read and accept all aspects of the Informed Consent and Policy and Procedures Agreement and understand that this Treatment Agreement is an extension.

Credit Card on File: _____

MM/YY: _____

CSC: _____

Zip Code: _____

Signature: _____ Date: _____