More MH Counseling
Make More Happen

Treatment Fee Agreement

Date: _____

Client information:
Name: _____ Insurance:_____
Age - Date of Birth: _____
Social Security #: _____
Driver's License #: _____
Gender: _____Male Female

Guardians:
Name: _____ Name: _____
Age - DOB: _____ Age – DOB: _____
Social Security #: _____ Social Security #: _____
Driver's License #: _____ Driver's License #: _____
Gender: _____Male Female 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 Consult: $1 per minute Treatment Letters: $30.00

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: _____