Jewish Family Services of Greenwich
1 Holly Hill Lane, Greenwich, CT 06830 • (203) 622-1881

FINANCIAL POLICY

I, ________________________________, agree to pay Jewish Family Services of Greenwich, for all psychotherapy services rendered. I attest that I have been informed of said charges.

If Psychotherapy services are covered by private insurance, benefits due to me under existing policies are hereby assigned to the above named provider. I permit a copy of the signature on this release to serve as a lifetime authorization. A copy of this form may be used in place of the original.

I understand that specific diagnostic and treatment information, may be required by third party payers and I consent to release of all requested information.

I understand that I (or the person financially responsible for me) am personally responsible for the cost of psychotherapy services including but not limited to unmet deductible, co-payment, co-insurance or any fees not paid by my insurance carrier. This also includes late payment and no-show fees.

Client signature: ____________________________________ Date: ___________
(or Guardian)

Payment of services is expected at the time services are rendered.

Current Fees: **$200.00 60 minute evaluation**
$175.00 60 minute ongoing psychotherapy
$175.00 60 minute family session
$150.00 45 minute ongoing psychotherapy
$75.00 Late Cancellation/no-show fee

I understand that if I am unable to keep my appointment I will provide a minimum of 24 hours notice. If I do not give the required notice, I agree to pay the $75.00 late cancellation/no-show fee. If there are any questions or concerns regarding my missed appointment, I will discuss at the next scheduled visit.

I hereby consent to the above stated financial policies.

Client Signature: _______________________________________ Date: ________________