Client Name: _____ **Insurance:** _____

I acknowledge that I am financially responsible for full payment of my (or my child's) services:

☐ Insurance-deemed patient portion OR ☐ Self-Pay Rates

Initial_____ I understand that Awake and Aware, LLC staff has contacted my insurance company regarding financial responsibilities, this is not a guarantee of payment. It is possible your financial responsibility will be determined upon submission of claim for rendering services.

Initial_____ I understand if my insurance changes, expires or terminates for any reason, I must notify the billing office immediately. If claims are denied or if a deductible has not been met per insurance payer, I will pay the following self-pay rates until the deductible is met.

Self-Pay Rates: $150.00 – Intake $125.00- Individual Session $75.00- Group Sessions Family Sessions: $100.00

Parenting Group Class- Included in the comprehensive DBT adolescent program

My co-pay will be $_____ for individual sessions
My co-pay will be $_____ for group sessions
My co-pay will be $_____ for family sessions
*Currently, we do not offer multiple services on the same day.

A credit card must be on file for copay amounts; co-payments are due at time of services and will be charged every Monday for services based on your weekly scheduled sessions. If I am unable to meet the specified copay amount during that time, I understand that any future appointment(s) may be cancelled until payment is made in full.

Responsible Party Signature: _____ Date: _____

If client has not paid an invoice exceeding 90 days, Awake & Aware LLC will refer that unpaid balance to a collections agency. Thereafter, client is responsible for paying all associated fees; future services will be cancelled until the account balance is paid in full.