PATIENT AGREEMENT

Please initial each of the following statements and sign below:

_____ I understand that no promises or guarantees have been made to me by Yara Counseling Group, LLC about the results of treatment, the effectiveness of the procedures used by Yara Counseling Group, LLC, or the number of sessions necessary for therapy to be effective.

_____ I understand that after therapy begins, I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with Yara Counseling Group, LLC before ending therapy. I understand I will be responsible for paying for services I have already received. I understand that if my treatment is court-ordered, it will be reported to the courts.

_____ PAYMENT POLICY: I understand that: if I have insurance, it is my responsibility to get pre-authorization, and I am responsible for my co-pay at time of service; if I am an out-of-network client or a self-pay client, payment is due in-full at time of service.

_____ CANCELLATION/MISSED APPOINTMENTS. I understand I must call to cancel at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged $50.00 for that appointment. Also, I understand my case will be closed for two broken or missed appointments.

_____ PAST DUE BALANCES. I understand that any balance past due is subject to interest accrual of 10% monthly. I agree that if my account falls into collections, I am responsible to pay interest, penalties, collections and any legal fees derived from this action. A reasonable collections charge will be added to your balance should collections services be necessary to receive payment for your treatment. At that point, confidentiality regarding your name and involvement in therapy can be broken. To avoid this, please pay your bill at the time of service.

_____ I am aware that an agent of my insurance company, third-party payer, or third-party biller may be given information about the type(s), costs(s), and date(s) of any services or treatments I receive. I understand that if payment for the services I receive is not made, the therapist may stop my treatment.

_____ I acknowledge that I have received a copy of Notice of Privacy Practices (NPP)

I seek and consent to take part in treatment by Yara Counseling Group, LLC. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. My signature below shows that I understand and agree with all of these statements.

_____	_____	_____
Patient Print Name	Patient Signature	Date
_____	_____	_____
Legal Guardian Print Name	Legal Guardian Signature	Date