Hope's Place
Linda Yearout, LCMFT
654 N. Woodchuck, Suite G
Wichita, KS 67152
316-217-5982

FEE AGREEMENT & INSURANCE BILLING WAIVER

Client Name: _____ DOB: _____

Address: _____

Phone: _____ EMAIL: _____

I, the undersigned, agree to pay $80 per session, payable at the time of service. I accept the responsibility of a 'private pay' client, and I understand I will be responsible for the charges for all counseling services.

I understand and agree that I am waiving insurance billing and no insurance claims will be submitted either party of this agreement.

I understand I will be given reasonable notice of any changes in fees. The use of collection agencies or legal measure for non-payment will be used only after reasonable efforts have been made for collection. Linda Yearout, LCMFT reserves the right to suspend or terminate services due to non-payment, within the limitations of the AAMFT Code of Ethics.

I hereby agree to the Fee Agreement / Waiver for Insurance Billing, and consent to the mental health treatment by Linda Yearout, Licensed Clinical Marriage & Family Therapist.

_____ _____

Client/Guardian/DPOA of Patient Date

_____ _____

Linda Yearout, LCMFT Date