

**Patient Self-Pay Agreement**

By signing this agreement, you have registered as a private pay client. This means that at the time of service you will be paying by FSA/HSA or debit/credit card. Due to this method of payment, you are receiving a discount for services. Your insurance will not be billed for services provided under this arrangement. No forms will be produced now, or in the future, for you or us to submit for insurance billing.

At the end of each session, you will receive a Super Bill statement where the fee can be paid. This bill can be used to submit to your insurance provider for possible reimbursement. PLEASE REACH OUT TO YOUR INSURANCE PROVIDER TO LEARN OF REIMBURSEMENT RATES AND OPTION. It is up to you to understand the benefits covered by your insurance provider.

I understand that I will be responsible for all charges related to the services provided to me by GreenSpace Counseling, LLC. \_\_\_\_\_

I understand that the charges presented to me are due in full on the day of service unless arrangements have been made in advance. \_\_\_\_\_

Self-Pay Rates have been discussed and agreed upon with Paris Taylor, LCSW-C, LICSW. \_\_\_\_\_\_

I will be responsible for logging into my client portal to add/update payment information.

\_\_\_\_\_\_

I have read and fully understand the above self-pay rates and I agree to waive insurance billing and pay my balance owed at the time of service. I also understand by signing this acknowledgement that I will be responsible to pay for the services rendered to me and/or my dependent.

Responsible Party Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_