DISCLOSURE STATEMENT

Client Name: ____ DOB: ___________ Age:_______

STATEMENT OF FEES:

Insurance billed services: Individual Therapy: $150 per session, Family Therapy: $200 per session. Group therapy: $100 per session.

Open Path Collective clients: Please provide confirmation of your enrollment. Fees are determined on a case by case basis.

I, ____________________________have reviewed Emerald Behavioral Health's fees and I am aware that they are subject to a sliding scale as negotiated if applicable.

Please read each item carefully and initial:

_________I understand that my private insurance will be billed for the therapy services at the rates listed above and that any cash paying clients will have rates negotiated at a sliding scale according to need.

_________I understand Emerald Behavioral Health accepts some insurance for eligible services.

_________ I understand that it is my responsibility to ensure services are covered by my insurance prior to onset.

_________I understand that the fees and terms of this statement can be changed with 30 days' notice.

_________I understand that payment/copay is due at the start of session for all clients.

My signature below attests to my having read and understood the information with my agreement to the terms and conditions outlined above.

Client/Parent/Guardian:____ Date: ____________

Client/Parent/Guardian:____ Date: ____________

Staff signature: ____Date: ____________