Returning to Compassion Counseling, LLC
1017 SW Morrison St. #507B
Portland, OR 97205
Tel 503-319-1095
ruthdiaz@mac.com
www.returningtocompassion.com

PSYCHOTHERAPY PAYMENT AGREEMENT

I, _____, agree to meet with Ruth Diaz, LPC, PsyD, ____ times per month and understand that the full fee for individual sessions is: $120.00 (other than the intake session, which is $130). My sessions will last 45-50 minutes. **I am aware that any cancellations of appointments must be made at least 24 hours before my appointment, unless it is an emergency and if I do not cancel or not show up, I will be charged for the full fee of that appointment.** I agree to be financially responsible for the cost of treatment and I am aware that if I have not paid for services received or worked out a payment arrangement with Ruth Diaz, LPC, PsyD, treatment may be discontinued.

Please choose one of the following options by initialing:

_____I am paying full fee for psychotherapy and am aware that I must bring cash or check to each appointment, or keep a credit card on file with Ruth Diaz, LPC, PsyD, unless other arrangements have been made.

_____I am electing to have my treatment to be paid in full or part by my insurance carrier or another third party, I will authorize this in writing and allow Ruth Diaz, LPC, PsyD, to release to an authorized agent of my insurance or a third-party payer information about the type(s), cost(s), date(s) of any service of treatment I receive. I am financially responsible for any portion of the fees not covered or reimbursed by my health insurance carrier. Further, I understand that I am responsible for preauthorizing sessions before beginning treatment and if I do not receive preauthorization, I am financially responsible for those sessions not covered by my insurance.

_____ I am not able to pay full fee for therapy. I have discussed a sliding scale fee or monthly subscription option with Ruth Diaz, LPC, PsyD and we have agreed upon _____ per session OR month as my fee.

I have been informed and agree to hold Ruth Diaz, LPC, PsyD, harmless from any losses, damages, liabilities, costs and expenses (including and without limitation of attorney's fees) arising from the release of such information to my insurance carrier, or to a third-party payer or to any other agent as designated by me.

Full Name (please Print) **Date of Birth**

Signature **Date**