Infinite Wellness LLC

Client Financial Responsibility Form

Thank you for choosing Infinite Wellness LLC for care. We ask that you read and sign this form to acknowledge and agree to accept financial responsibility for services rendered by Provider to Client.

I agree that I am legally responsible and agree to pay to the Provider for all fees, charges and expenses incurred by the below Client or owed to [Infinite Wellness LLC] in connection to Provider providing care to Client.

Self Pay Rates:

Client Intake/ First Session: $200/hour

Follow up Psychotherapy Sessions: $175/60 min session or $150/45 min session

Other Professional Services:

Health insurance companies will help pay for psychotherapy sessions, however, they do not pay for optional services outside of the session. The cost of letter writing and phone consultation services will be broken down into 15 minute increments with an hourly rate of $175. An hourly rate of $300 will be charged for a records request. I understand that my health insurance provider will not cover the cost of these services and my card on file will be charged.

Letter Writing: $175/60 minutes

Phone Consultation: $175/60 minutes

Records request: $300/60 minutes

I acknowledge and agree that I am ultimately responsible for the payment to Provider for any and all services rendered by Provider to Client.

Printed Name of Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_