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|  | **Robert Jensen, PLLC**MHP, Licensed Mental Health Counselor15324 Main Street, Suite BSumner, WA 98390253-830-4119 [Phone]ROBERTJ@tsecuremail.com [email] |

**Financial Agreement**

**Sessions:**

Therapy hours are usually 50 minutes long plus an additional 5 minutes prior to the appointment for the therapist to prepare and 5 minutes after to complete the paperwork required by legal and ethical regulations. Longer or shorter appointments can be arranged with enough notice given.

Initial intake appointments require longer time periods. These can go anywhere from 50 minutes to 80 minutes and include more setup work after the appointment. For your initial appointment plan for an hour and a half but know that it may take anywhere from one hour to the full hour and a half.

**Missed/Cancelled appointments:**

We ask that you provide 24 hours notice if you need to cancel an appointment due to time and space restrictions there may be people waiting for an appointment that can fit that time slot. We ask that you please respect your treatment, our time, and our other clients and give ample notice if you need to miss an appointment. Missed or no show appointments without 24 hours notice will incur a charge of $50 dollars insurance will not reimburse for missed appointments. In the case of an emergency if you are forced to miss your appointment no charge will be applied.

**Fees:**

$140 for 90 minute session

$140 for initial intake appointment

$100 for 50 minute session

$50 for 30 minute session

$50 for Appointments cancelled without 24 hours notice.

Fees are subject to change with notice given prior to the change. Financial arrangements will be discussed during the initial appointment. If your financial situation changes and you need assistance there are some options to assist with covering services. It is your responsibility to address financial needs with me as they change.

**Client/Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:**

**Therapist Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date:**