Pine Bush Mental Health, LLP
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Financial Agreement

I, _____, on behalf of myself or _____
Request services from Pine Bush Mental Health and understand that I am responsible for the portion of these services not covered by insurance. I agree to obtain prior authorization for treatment as maybe required by my insurer. I agree to keep my account currant and to pay for any missed sessions unless I inform the office of the cancellation 24 hours in advance. I understand that I will be charged for any missed sessions and such fees are not reimbursable by insurance. I will pay at the time of service unless I have made other arrangements with my doctor.

Confidentiality Statement

I understand that what I discuss in therapy will be treated confidentially in accordance with law and recognized professional standards. I understand that only I can give up my right to privacy by signing a release. I also understand that the limits of confidentiality do not extend to:

- Situations involving child abuse or neglect
- Situations where Pine Bush Mental Health believes that I might harm myself or others
- If a court of law issues a legitimate subpoena

Agreement

I have read the above statements, understand and agree to them as written. I permit a copy of this authorization to be used in place of the original.

If there is any part of this agreement you question or do not understand, please do not sign it until you have discussed it with your therapist.

Signature_____ Date_____

Witness_____ Date_____