



### SLIDING SCALE PAYMENT AGREEMENT

I, \_\_\_\_\_, am choosing to make cash/card/check payments for the clinical services I receive at The Works Counseling Center. I am doing this for the following reason(s):

- I do not presently have insurance with mental health benefits.
- I have mental health benefits with \_\_\_\_\_ (Insurance Company)

However:

- I am choosing not to use my insurance benefits at the present time.
- I wish to be treated by Angelique Howington Works, LPC-MHSP (temp), who is not a paneled member of my insurance network ("out of network" status).
- My concerns are not covered by my insurance benefits or are not deemed medically necessary by my insurer.

I agree to pay:

- \$ 68 per 50-minute session

This agreement pertains to services beginning \_\_\_\_\_ (date) and will remain in effect until such time as a new written agreement is made, or a valid insurance authorization is obtained, and I consent for The Works Counseling Center to bill my insurance. I agree to make cash payments in full at the time that services are rendered. I further understand that therapist will not "back bill" my insurance company or provide superbills to me for retroactive reimbursement.

Client/Legal Guardian Signature: \_\_\_\_\_

Client Name (Please Print): \_\_\_\_\_

Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

