Tamara Allen Bush LLC

Tamara Allen Bush, LPC-S, NCC, CSAT

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Fee Information and Office Policy

Financial policy

Thank you for trusting me as your health care provider. I appreciate your trust and I appreciate the opportunity to serve you. I am committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of my Financial Policy, which I require you to read and sign prior to any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

- **I accept cash, Credit Cards (Visa, Mastercard, Discover Card, American Express, and some health savings cards), Zelle and Checks.**

Regarding Insurance:

If you wish to be reimbursed by your insurance company please let me know so I may provide the appropriate form to your insurance company at the time of your session. I will need you to complete the Insurance Information section of the Patient History Form.

My rate is $200.00 for initial assessment and then $150.00 hourly

Adult patients are responsible for full payment at the time of service. The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment at the time of service and will also be required to sign a Consent for Treatment Form.

Missed Appointments:

Unless an appointment is cancelled at least 24 hours in advance, my policy is to charge $100.00 for a missed session. If an absence is unavoidable (illness, crisis, etc.) this will be considered prior to charging the missed appointment fee. Two missed sessions will result in the no show charge. Please help me to serve all my patients better by keeping scheduled appointments. By signing below, you are indicating that you read and understood this policy, that any questions you had about this policy were answered to your satisfaction, and that you were furnished a copy of this Financial Policy. Per the No Surprises Act, a Good Faith Estimate will also be provided at the time of the first meeting.

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Printed Name of Patient or Responsible Party

_____ _____

Signature of the Patient or Responsible Party Date

_____ _____

Signature of the Therapist Date