



Virginia Celmer, IHM, PhD, LCDC

Licensed Psychologist

Licensed Chemical Dependency Counselor

PATIENT FINANCIAL AGREEMENT

I hereby agree to pay any deductible and co-payment owing on my account according to the terms agreed upon between myself and Dr. Virginia Celmer (or full payment if I do not have insurance filed on my behalf.) If this agreement is anything other than the rates determined by my insurance carrier or Doctor Celmer's usual and customary fees, such terms are noted and initialed below.

I further acknowledge in signing this agreement that:

- I am aware that a 24-hour notice is required for canceling appointments, except in cases of family, medical, or work emergency. Failing this, or failing to report for my appointment without prior notification, will result in my account being assessed for the missed appointment at Doctor Celmer's usual and customary rates (\$115 for an individual appointment and \$125 for a couples therapy appointment.) I understand that this cost cannot be charged to my insurance company or a third party and that I will be responsible for the total cost of the appointment.
- I am aware that payment to Doctor Celmer can be made by cash, check, money order or credit card, including health savings account cards (HSA.)
- I am aware that a \$50 fee will be added to my account each time a check is returned to Doctor Celmer for insufficient funds. I understand that after two such charges to my account, all payments for services rendered to me must be made in either cash or by money order.

Signature of Patient/Responsible Party

Date

INFORMED CONSENT TO TREATMENT

My signature below indicates that I have received a copy of the Outpatient Services Contract, that I have had an opportunity to have any questions answered, that I agree to abide by its terms, and that I consent to treatment by Virginia Celmer, IHM, PhD, LCDC.

Signature of Patient/Responsible Party

Date

6/2015