FINANCIAL INFORMATION
Rachel Newman, MA, MRP, LMHCA

Appointments are 55 minutes and payment must be made by check or cash at the beginning of the session. Sessions are billed at the rate of:

Individual Therapy $100/hr
Family Therapy $125/hr
Couples Therapy $125/hr
Group Therapy $50/hr
Legal Work $225/hr

Please initial after each paragraph.
Phone Consultation: Emergency, and professional consultation telephone sessions are billed at the same rate, in quarter hour segments, after the first five (5) minutes. _____ (Initial here)

Cancellation Policy: You are asked to cancel any appointment at least 24 hours in advance. **The full fee will be charged for missed appointments and cancellations with less than 24 hours notice. _____ (Initial here)**

Payment is due at the beginning of the sessions unless prior arrangements have been made. I ask that you have your check made out in advance and pay as you enter the session. This will allow us to devote our entire attention to the therapy process. Some insurance plans cover mental health services. I recommend that you check with your insurance carrier directly to see what your specific benefits are, as **I do not bill insurance,** but can provide you with a receipt to submit for possible reimbursement. You are responsible for your account and are expected to pay for all services you receive. Any balances outstanding after 60 days may be charged an interest fee per month on the unpaid balance. _____ (Initial here)

This contract is exclusively with Rachel Newman, MA, MRP, LMHCA. My work with you is as an independent practitioner and not in affiliation with any group practice, or other practitioner in this, or any other building. Individual mental health practitioners assume no liability or responsibility for any other practitioner or group working in this office or building. _____ (Initial here)

Having read the above contract, I understand my responsibilities for payment. My (our) signature(s) confirms acceptance of the above items and constitutes informed consent for psychotherapy without exception.

_____	_____	_____
Name (Print)	Client Signature	Date
_____	_____	_____
Name (Print)	Client Signature	Date
_____	_____	_____
Rachel Newman	Therapist Signature	Date