



Payment Policies

Please read and completely fill out the form below.

Before your first scheduled session, you are required to have a valid credit/debit card on file.


For private pay clients, membership clients, for any co-pays, co-insurances or deductibles that are not captured by a separate service, I utilize my electronic health record system (Practice-Q) that is HIPAA and PCI Compliant. There is a form below to capture your CC information.

- By completing and signing this Payment Agreement, you are indicating that you understand and agree to provide a valid credit/debit card number, with expiration date, for payment of future appointments, services, or other fees.
- Your signature indicates you understand that if you do not attend a scheduled appointment your credit card will be charged a \$25 no-show fee unless you cancel your appointment at least 24 hours in advance.
- Your credit card number will be kept on file throughout treatment and will be charged only for balances not paid by insurance, and copays if applicable. It is expected that your session be paid for by or at the time of service, unless other arrangements have been made. I reserve the right to refuse services if payment is not made.
- Your signature indicates that you may be charged for other services such as, extended sessions, and other services rendered on your behalf.
 - **EXAMPLES:** Other professional services include requested forms, follow up meetings lasting longer than the allotted time frame, preparation of treatment summaries, professional letters, court ordered legal proceedings, and the time spent performing any other service you may request of me.
- Your signature indicates that you are an authorized card user for the card you are placing on file.
- If you are using your insurance for receiving services, you will be asked to fill out a separate authorization to bill insurance. It is your responsibility to know your benefits and to pay for your sessions.
 - If a session is not covered due to lapse of benefits or change in carrier, and you do not notify me of this change, you will be charged my current "self pay" fees. Please review the insurance payment form for more information.
- Please refer the the below table for current self-pay pricing, membership pricing, and other specific service fees.

Medical Marijuana Consultation	\$120
Official Forms/Letters Requests	\$50
Self-Pay Initial Consultation	\$250
Self-Pay Follow up session	\$120
Membership	\$85/month *12-month contract on autopay (contact customer service for details)

I understand that a re-billing fee/financial charge complying with Maryland State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. A copy of this agreement will be available in your client portal.

If you are a parent or guardian, please state your child's name here:

 CREDIT CARD INFORMATION

Name on Card

Credit Card Number

Expiration Date Security Code Postal Code

Client Signature

Date

Provider Signature

Date