Sojourn Counseling
2120 60th Ave NE
Wilmar, MN 56201
Phone: 320.905.4345 Fax: 218.507.8492
www.sojourncounselinggroup.com

Date of Service: Client: DOB

Surprise Billing Protection

The purpose of this document is to protect you from unexpected medical bills and give you the option of waiving these protections for out-of-network care.

IMPORTANT: You are not required to sign this form. Please do not sign this form if you do not have a choice of health care providers when you received care. You may choose to receive care from a provider or facility in your health plan's network, which may cost less. If you would like assistance with this document, please ask your provider or a patient advocate. You may also take a photograph, and/or keep a copy of this form for your records.

If your plan covers the service you are receiving, federal law protects you from higher bills:

- When you receive emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

If you sign this form, you may pay more for services for the following reasons:

- You are forfeiting your protections under the law.
- You may owe the full costs billed to you for items and services received.
- Your health plan may not include payments towards deductibles and out-of-pocket limit.

Please contact your health plan for more information. You should not sign this form if you did not have a choice of providers when receiving care. Before signing this form, you may contact your health plan to find an in-network provider or facility, or your health plan may negotiate an agreement with this provider.

Total cost estimate of what you may be asked to pay:

- Review your detailed estimate. See Page 3 for a cost estimate for each item or service you may get.
- Call your health plan. Your plan may have additional information on cost estimates and coverage options.
- Questions about this notice and estimate? Call the provider that sent it to you, Sojourn Counseling's telephone number is 320-905-4345.
- Questions about your rights? Visit https://www.cms.gov/nosurprises for more information.

Prior authorization or other care management limitations

Your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's prior approval to cover services. If prior authorization is required, contact your health plan.

Understanding your options

You may request a description of services listed in this notice from these providers who are in-network with your health plan:

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I agree to services from Sojourn Counseling Group.

- With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:
- I'm giving up consumer billing protections under federal law.
- I may receive a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I received written notice on explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I received the notice either on paper or electronically, consistent with my choice.

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- I received the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before receiving services.

IMPORTANT: You don't have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

Name of Patient:

Patient Signature: _____

Name of Guardian/Authorized Representative:

Guardian/Authorized Representative Signature: _____

Take a picture and/or keep a copy of this form. It contains important information about your rights and protections.

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more about this process, go to www.cms.gov/nosurprises For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurpriseswww.cms.gov/nosurprises.For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises.

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Keep a copy of this Good Faith Estimate.

Good Faith Estimate for Behavioral Health Care Out-Patient Services

Patient			Date of Good Faith Estimate:
Patient First Name	Middle Initial	Last Name	Patient Date of Birth
Patient Mailing Address, Phone Number, and Email Address			
Street or PO Box			Apartment
City	State		ZIP Code
Phone	Email Address		
Patient's Contact Preference:	☐ By mail ☐ By email		
Patient Diagnosis			
Patient Primary Diagnosis Unspecified dementia without behavioral disturbance			Primary Diagnosis Code
If scheduled, list the date(s) the Primary Service to be provided: ☐ Check this box if this service or item is not yet scheduled			
Provider Name			**Estimated Cost per Service: $200.00**

The following is a detailed list of expected charges for your upcoming appointments. The estimated costs are valid for the 2024 calendar year. This includes face to face and telehealth.		
Procedure Code/Service Description	Billed to Insurance	Private/Cash Pay
90791 Diagnostic Assessment	$350	$225
90837 Psychotherapy 60 mins (53 plus) *Most Common/Reoccuring as needed	$300	$175
90847 Psychotherapy Family Session 60 mins	$300	$200
NO SHOW/Late Cancel Fee - OUT OF POCKET $175.00	N/A	$175

Many fees associated with therapy are not covered by insurance companies such as consulting and correspondence with other therapists or doctors. Such services will be billed Private/Cash Pay at the full hour session rate.

Court or legal activity such as preparing reports, consulting with attorneys, court preparation, or being subpoena to appear in court is a $500 per hour Private Pay/Cash rate.

Copies of documents sent on your behalf will have a $1/page plus postage charge.

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Informed Consent & Agreement for Therapy Services

Welcome to Sojourn Counseling Group. We are a group of mental health providers who are committed to helping others. This document contains important information about our professional services and business policies. The informed consent is a basic understanding between client and therapist. Listed below are the responsibilities and obligations of the therapist and also some expectations of you or your child as the client. It also contains information about your and/or your child's health information privacy rights. Do not sign the informed consent unless you completely understand and agree to all aspects. If you have any questions, please bring this form back to your next session. We can go through this document in as much detail as is needed.

When you sign this document, it will represent a binding agreement between you, your therapist and Sojourn Counseling Group.

What to expect: The initial session, and possibly the first few sessions, will involve an evaluation of your situation, needs and the goals you'd like to work towards. Additionally, you may be asked to complete a mental health questionnaire so we can gain additional information as it relates to your past and current symptoms. Other assessments may also be completed to assist in formulating an accurate diagnostic assessment and treatment plan. Information will be provided during your sessions so that you will have an idea of what your therapy work will entail. Therapy is meant to be a collaborative experience and we will assist in answering your questions to help you to feel comfortable and informed about your treatment. If you have any questions about any aspect of therapy, please ask, we are not a very good mind readers.

Voluntary Participation/Termination: All clients voluntarily agree to treatment and accordingly may terminate at any time without penalty. Counseling involves a large commitment of time, money and energy so it is important that you select a therapist you are comfortable working with. In the first couple of sessions, you should decide whether your therapist is the right therapist for you. If you feel it is not a good match, we will help you locate another therapist or find other appropriate resources to meet your needs.

Therapist's Qualifications/Therapy Approach: Sojourn Counseling Group contracts therapists that are licensed by the state of Minnesota Board of Marriage and Family Therapy, the Minnesota Board of Behavioral Health and Therapy, the Minnesota Board of Social Work, and the state of Nevada's Board of Examiners of Marriage and Family Therapy. We use varying therapy approaches, often based on our training, and/or specific field of study. Generally the therapy approach will include a cognitive--behavioral, dialectical behavior therapy, solution focused, family systems, motivational interviewing or humanistic orientation to counseling. Additionally, other therapy approaches are used to address specific problems or issues, and can be discussed further as needed.

Risks/Benefits of Therapy: There are both risks and benefits of therapy. Counseling and psychotherapy has been shown to have benefits that may include: improved mood, better relationships, improved communication, symptomatic relief, improved self-worth, increased life satisfaction, reduction in distress, improved physical health, and solutions to specific problems among others. The risks of therapy may include: feelings of sadness, anger, guilt, betrayal, frustration, loneliness, and helplessness. Other risks may include stimulation of difficult memories or experiencing changes not anticipated. In some situations a client's symptoms worsen during the course of therapy to the point of requiring hospitalization.

Technology-Assisted Therapy Services: When telehealth, or technology-assisted therapy services, have been agreed upon by the counselor and the client, counselors will ensure that they abide by all laws and ethics regarding the provision of services and discuss potential risks and benefits with clients. Additionally, counselors will ensure that telehealth is appropriate for the client, given their individual mental, emotional, intellectual, professional, and physical needs; discuss and minimize potential risks of technology-assisted services; ensure the security and confidentiality of all modalities used.

Therapy for Minors and Custody: In cases where there is joint legal custody between parents or guardians who are not married or cohabitating, we require both parents' authorization and signature for treatment of their minor child/children, prior to the child being seen. In cases where one parent has sole legal custody of their minor child/children, only that parent is required to authorize treatment.

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Sessions and Length of Therapy: Typically sessions are 22 to 80 minutes in duration, at a time we agree upon. If you arrive late for your scheduled appointment, we can meet for the remainder of our scheduled session, if you inform your therapist in advance. Sessions are usually scheduled once weekly but can be more or less often based on your needs, treatment plan and your therapist's recommendation. Length of therapy is variable and based on a number of circumstances.

Cancellations/No Shows: Please call or text at least 24 hours in advance if you need to cancel or reschedule a therapy session at the counselor phone number provided to you at the first session. You will be charged the full rate for late cancellations or missed scheduled sessions (no shows) unless we both agree that this occurred due to circumstances beyond your control. If you miss three scheduled sessions without giving a 24 hour notice, we will discuss referrals to appropriate resources for you to use.

Professional Fees: The therapy hourly rate is $300.00 for a 45--minute therapy hour unless an agreed upon lower rate is calculated based on your income. Any rate changes are reflected in the Treatment and Financial Agreement you will complete at the time of your first session. Fees for other professional services such as report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals you have authorized, preparation of records or treatment summaries etc, are charged the therapy rate on a pro--rated basis.

If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for our professional time even if we are called to testify by another party. Because of the complexity and difficulty of legal involvement, the fees are $500.00 per hour for preparation and attendance at any legal proceeding.

Billing and Payment: You will be required to make payments in full prior to each therapy or counseling session, unless we agree otherwise, stated in writing. Payment must also be made prior to providing other professional services requested. Payment options include: cash, credit card, and check. We process credit cards using secure, online credit card processing and merchant services such as PayPal. If you make a payment by check and your check does not clear due to insufficient funds or any other reason, you will be expected to pay in full plus any related banking fees assessed as a result.

Outstanding Balance/Collections: If a client's invoice reaches an outstanding balance of $300 and no payments have been made or received toward the account, additional counseling sessions will be put on hold until payments have resumed. If no payments are made, future session will remain suspended and/or clients may be provided with referrals for other services or providers. If you have not made a payment to your account for longer than 90 days, and arrangements for payments have not been made in writing, we reserve the right to seek legal means to secure the payments. This may include involving a collections agency or going through small claims court. This disclaimer may be waived under certain Medicare/Medicaid rules.

Professional Records: The laws and standards of our profession require that we keep electronic treatment records. Sojourn Counseling Group, utilizes the electronic health record offered by Procentive. Some forms may be sent to you via the kiosk feature of Procentive, which is an electronic health record compliant with federal and state security, privacy and confidentiality laws. You are entitled to examine and/or receive a copy of your records unless we believe reading them would be emotionally damaging in which case we would recommend reviewing them together or sending them to a mental health professional of your choosing. Because these are professional records, they can be easily misunderstood, misinterpreted, or upsetting to people who are not trained professionals. Clients will be charged $1.00 per page and a $15.00 administrative fee for the cost of copying and sending records if requested. All records will be kept by your therapist in a secured area for a period of 7 years from the termination of your therapy services.

Counseling/Records for Minors: If you are under 18 years of age, and not emancipated, the law provides your parents the right to review your treatment records as well as discuss your treatment, diagnosis and progress with your therapist. Minor children do have the rights to complete confidentiality in obtaining counseling for pregnancies and associated conditions, sexually transmitted diseases and information about alcohol or drug use.

Changes in Eligibility, Services or Rates: Please inform us of any changes in your financial status and insurance or medical assistance eligibility. We reserve the right to make changes to the policies, practices and rates described in this

document. You will be notified in writing within 30 days prior to any significant changes.

Confidentiality and Privilege: In general, the law protects the privacy of all communication between a client and a therapist. We can only release information about your treatment to others if you sign a written authorization form. You can revoke any such authorizations at any time in writing. The information and content shared in therapy will remain confidential except when your therapist is legally mandated to release it, as listed in the section below. Your information is also privileged meaning your therapist cannot speak in court about your counseling unless you waive that right or a judge orders it.

Exceptions to Confidentiality and Privilege: As a mandate reported in the state of Minnesota your therapist is legally obligated to violate confidentiality under the following circumstances:

1. Therapist's duty to warn another in the case of potential suicide, homicide or threat of imminent, serious harm to another individual.
2. Therapist's duty to report suspicion of abuse or neglect of children or vulnerable adults.
3. Therapist's duty to report prenatal exposure to cocaine, heroin, phencyclidine, methamphetamine, amphetamine or their derivatives, THC, and excesses and habitual use of alcohol.
4. Therapist's duty to report the misconduct of mental health or health care professionals.
5. Therapist's duty to provide a spouse or parent of a deceased client access to their child or spouse's records.
6. Therapist's duty to provide parents of minor children access to their child's records. Minor clients can request, in writing, that particular information not be disclosed to parents. Such a request should be discussed with the therapist.
7. Therapist's duty to release records if subpoenaed by the courts.
8. Therapist's obligations to contracts (e.g. to employer of client, to an insurance carrier or health plan.)

Additional client rights are listed in detail on the Notices of Privacy/Health Insurance Portability and Accountability Act (HIPAA). Any complaints or concerns that cannot be resolved between the client, therapist and Sojourn Counseling Group, can be directed to MN Board of Marriage and Family Therapy, University Park Plaza Building, 2829 University Avenue SE, Suite 330, Minneapolis MN 55414-3222, and Minnesota Board of Behavioral Health and Therapy, 2829 University Avenue SE #210 Minneapolis MN 55414.

Contacting your Therapist/Crisis: Due to our obligations with clients we are not often immediately available by phone. We do not answer our phone when we are with clients and typically return phone calls between sessions, if possible, or after hours. When we am not available, you may leave your therapist a confidential voice message and we will attempt to return your call the same day or within the next business day. If you are difficult to reach, please identify the best time to return your call. When returning calls, we will assume it is ok to leave a message unless you state otherwise. While many clients choose to use text messaging or e-mail correspondence to schedule sessions or send messages to their therapist, we cannot guarantee their confidentiality. If you are experiencing a mental health or substance abuse crisis, please contact the crisis connection at 320-905-4345, to speak to a counselor. In cases of immediate need call 911 or go to your local emergency services.

Please read this document carefully and discuss any questions or concerns you may have with your therapist. Once you have read and understand the Informed Consent and Agreement for Therapy Services print and/or sign the signature page that follows. It will be kept in your file.Sojourn Counseling Group:

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As part of providing services to you, we will collect information about your health care. We need this information to provide you with quality services and to comply with certain legal requirements. This notice applies to all of the records of your care generated at or located at Sojourn Counseling Group. The law requires us to:

A. Make sure that information that identifies you is kept private;

B. Give you this notice of our legal duties and privacy practices with respect to information about you; and

C. Follow the terms of the Notice that is currently in effect.

How We May Use and Disclose Information about You:

Listed below are a number of reasons or ways in which information about you might be disclosed. In each category we will explain what we mean and give an example. NOT EVERY USE OR DISCLOSURE IN A CATEGORY WILL BE LISTED. The ways we might disclose information include:

A. For Treatment:

We may disclose information about you to any personnel at Sojourn Counseling Group or outside of Sojourn Counseling Group who are involved in our care. For example, your direct care staff may need to share information about your medications with your psychiatrist, or with your case manager.

B. For Payment:

We may use and disclose information about you so that services may be billed and payment may be collected from you, an insurance company, or a government health program. We may also tell your health plan about a service you may receive to obtain prior approval or to determine whether your health plan will cover the treatment.

C. For Health Care Operations:

We may use information about you to run our program and to make sure you receive quality services, or to decide if we should change or modify our services.

D. As Required By Law:

We will disclose information about you required by federal, state, or local law. For example, we may reveal information about you to the proper authorities to report suspected abuse or neglect.

E. To Avoid a Serious Threat to Health or Safety:

We may use or disclose information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

F. Military and Veterans:

If you are a member of the armed forces, we may release information about you as required by military command authorities.

G. Workers' Compensation:

We may release information about you for workers' compensation or similar programs when required by law to do so. For example, if you are involved in a claim for workers' compensation benefits, we may release information requested about your health.

H. Health Oversight Activities:

We may disclose information to a health oversight agency for activities authorized by law. Examples are government audits, investigations, inspections and licensure.

I. Lawsuits and Disputes:

If you are involved in a lawsuit or dispute, or if there is a lawsuit or dispute concerning your services or someone who provided services to you, we may disclose information about you in response to a court or administrative order. We may disclose information about you in response to a subpoena, discovery request, or other lawful process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

J. Law Enforcement:

In certain situations, we may release information about you to law enforcement officials. For example, we might release information about you to identify or locate a missing person about a death that may be the result of criminal conduct or in emergency circumstances to report a crime, the location of the crime or victims, or the

criminal conduct or in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description of location of the person believed to have committed the crime.

K. Coroners, Medical Examiners and Funeral Directors:

We may release information to a coroner or medical examiner to identify a deceased person or determinate a cause of death. We may release information to funeral directors as necessary to help them carry out their duties.

L. National Security and Intelligence, Protective Services for the President and Others:

We may release information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

M. Correctional Programs:

If you are an inmate or in the custody of a law enforcement officer, we may release information about you to the correctional institution or law enforcement official, for example, to protect your health and safety or the health and safety of others.

N. Civil Commitment:

In certain circumstances, your records may be released without your consent as part of a civil commitment proceeding.

O. Marketing:

Generally, we will not use your information for marketing purposes without your consent.

P. Psychotherapy Notes:

Private notes taken by a therapist in a therapy session generally will not be released without your authorization.

Q. Fundraising:

We may contact you for fundraising purposes however, you may ask us not to send you further fundraising requests, and we will honor your request.

R. Disclosure of Immunization Records to School:

We may, upon request by a school, provide proof of immunization to a school if the law requires the school to have this information before a student is admitted. We will try to get your consent or the consent of you parent or guardian before we do this.

Your Rights Regarding Information About You:

You have the following rights:

1. To Inspect and Copy your Service Records:

Usually this includes medical and billing records, but may exclude psychotherapy notes. To inspect and copy information in your record, you must submit your request in writing to the Program Director, Administrator or HIPAA Compliance Officer. We may charge a fee for the costs of copying, mailing or other costs related to your request.

In very limited circumstances, we may deny your request. If we deny your request, you may ask that the denial be reviewed. Another licensed health care professional of Sojourn Counseling Group's choice will review your request for review.

2. To Amend Your Record:

If the information we have about you is incorrect or incomplete, you may make a written request to the HIPAA Compliance Officer to amend the information. You must include a reason that supports your request.

We may deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that:

a Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

b Is not part of the information kept in our file;

c Is not part of the information you would be permitted to inspect and copy; or

d We believe the information is accurate and complete.

If you disagree with the denial, you may submit a statement of disagreement. If you request an amendment to your record, we will include your request in the record, whether the amendment is accepted or not.

3. To Receive an Accounting of Disclosures:

   We will keep a log of disclosures made on or after April 13, 2003, other than disclosures for treatment, billing or health care operations. You have the right to request the list of disclosures. You must submit a written request to the HIPAA Compliance Officer. The request may not cover more than a six-year period.

4. To Request Restrictions:

   You may request a restriction on the disclosure of information about you for treatment, payment or health care operations. Your request must be writing and made to the HIPAA Compliance Officer. Your request must tell us 1) what information you want to limit 2)whether you want to limit our use, our disclosure or both and 3) to whom you want the limit to apply. For example, you could ask that we not use or disclose information to a certain person about services you've received.

   We do not have to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

5. To Request Alternative Ways to Communicate:

   You may request that we communicate with you about your services in a certain way or at a certain location. For example, you can ask that we contact you only at work, or only by mail. Your request must be in writing, must tell us how you would like us to communicate with you, and must be sent to the HIPAA Compliance Officer. We will accommodate all reasonable requests.

6. To Receive a Paper Copy or Electronic Copy of this Notice:

   You have the right to receive a paper copy or an electronic copy of this notice. You may request either a paper or an electronic notice from the HIPAA Compliance Officer.

7. To be Notified if there is a Breach:

   If there is an unauthorized release of your information, we will notify you of this breach promptly and will offer suggestions on how to minimize damage that might result from the breach.

ADDITIONAL RIGHTS UNDER STATE LAW:

State privacy laws may provide additional privacy protections. Any such protections will be attached in a separate State addendum to this Notice.

CHANGES TO THIS NOTICE:

We may change this notice in the future. We can make the revised or changed notice effect for information we already have about you as well as any information we have in the future.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with the HIPAA Compliance Officer.

ELECTRONIC ACCESS:

If your health records are stored electronically, you may make arrangements to access an electronic version of these records.

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Internal Complaint Procedure:
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Complaints may also be made directly to the government at:

Office for Civil Rights
U.S. Department of Health and Human Services 200 Independence Avenue, S.W.
Room 515F HHH Bldg.
Washington, D.C. 20201

All complaints must be in writing. We will not retaliate against you for filing a complaint.

Informed Consent and Agreement for Therapy Services
As a client, my signature below indicates that I have been provided with a copy of the Informed Consent and Agreement for Therapy Services. My signature below also confirms that I have read and understand the information in this document. My signature constitutes my agreement and compliance to this document during the course of our professional relationship. My signature below also indicated that I have been provided with, read and understand the information contained in the Health Insurance Portability and Accountability Act (HIPAA).

Client Name: DOB:

Address Phone:

Client Name	Signature	Date
If client is a minor, caregiver name	Signature	Date
If client is a minor, caregiver name	Signature	Date

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No-Show/Cancellation Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that when you cancel your appointment you provide at least a 24 hours notice.

Call: 320-905-4345

Clients who do not appear for their appointment without a call to cancel will be considered a No-Show. Clients who cancel with less than 24 hours notice of your scheduled appointment or appear 15 minutes late for their session are considered a Late Cancel.

The following policy will apply to clients with Nevada Medicaid, Minnesota Care (MA, Blueplus, Primewest or Ucare) and other state and county insurances:

A maximum of three No Show/Late Cancel occurrences are allowed in one calendar year. Should clients exceed this, they will be referred to another provider or placed on a waitlist within the agency. All following recurring appointments with be cancelled and rescheduled per the clinician.

The following policy will apply to clients with Commercial Insurance and Private Pay coverage:

No Show/Late Cancellation appointments will be charged private pate rate of $175 for their session. All following recurring appointments with be cancelled and rescheduled per the clinician. If clients cancel within 24 hours and their session cannot be filled by another appointment, clients will be charged the private pay rate of $175 of their session.

_____
Printed Client Name

_____
Client Signature

_____
Date