Shirley Therapeutic and Consulting Services, LLC
Parkway Commons , 611 Russell Pkwy, Suite A ,Warner Robins, GA 31088

Patient's Name: _____ Date: _____

I _____ understand that my insurance company will be sent an itemized bill for each session in accordance to the reasonable and customary charges for such services. I agree to assign benefits directly to _____for all therapy services rendered. I also agree to remit any monies sent to me in error from my insurance company for services rendered to **Shirley Therapeutic and Consulting Services, LLC**. I agree to pay for all services rendered should my insurance company deny payment for services rendered, and will be responsible for any deductible, co-insurance or co-payment, to be paid at the time of my visit. Acceptable forms of payment include: cash, American Express, Master Card, Visa and Discover. Unfortunately, we do NOT accept personal checks.

For patients who pay privately or have out-of-network benefits, payments are due at the time of your visit. The fee for service for an initial evaluation is $135.00. The fee for service for all follow-up visits is $65.00.

CANCELLATION and DISCONTINUANCE FROM SERVICES POLICY

This office requires 48 hours' notice for cancellations. Otherwise, you will be charged the full fee of the session. In addition, you will be charged the full fee for the session if you do not show for a confirmed appointment. Should you miss three consecutive visits it will be considered that you are not in adherence or compliance with your plan of care, and will be discharged from this office.

I have read and agreed to the above policies and procedures.

Patient or Responsible Party Signature_____ Date_____