



Center for Gender Wholeness

Financial Agreement

This document contains important information and sets forth a financial agreement between you and CGW. Please read it carefully and initial or sign where required.

BROKEN APPOINTMENTS: Please notify your therapist at least 48 hours in advance if you must break an appointment. Appointments broken with less than 24-hour notice will be subject to full charge (genuine emergencies may be excepted at the therapist’s discretion).

Initial _____

INSURANCE REIMBURSEMENT: We do not bill insurance companies for payment. However, upon request we can provide you with a “superbill” that you can present to your insurance company for reimbursement. Since each insurance company has its own coverage policies, and since each individual presents a different set of symptoms and treatment needs, we cannot guarantee that your insurance carrier will cover all or any of your therapy.

CONFIDENTIALITY: In addition to confidentiality as outlined in the Informed Consent, there may be a limited disclosure if a financial collection action becomes necessary.

You may instruct us to share information about you with another person or entity (e.g., an insurance company or another therapist). But this can only be done through a written and signed waiver of confidentiality for that specific person or entity.

Initial _____

GOVERNING LAW: This agreement and all issues arising concerning this agreement are to be governed by the laws of the State of Utah. Any disputes over the interpretation or enforcement of this agreement are to be construed in accordance with Utah law.

Initial _____

FEE: Your fee for individual therapy sessions is \$200 per 90 minutes. Fees are due and payable at the time of service.

I understand this information and agree to the foregoing terms and conditions.

Signature of individual responsible for payment: _____

Relationship to Client: _____

Date: _____

CREDIT CARD PAYMENT AGREEMENT:

By signing your name below, you authorize CGW to charge your credit card account for services rendered at the rate of \$200 per 90 minute session.

VISA MasterCard Discover American Express (\$5 processing fee)

Card No. _____ Exp Date: _____

Cardholder's name: _____

Cardholder's billing address:

Street: _____

City: _____ State: _____ ZIP: _____