Fee Agreement
For Out of Pocket Services

Harte
Behavioral
Health

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I agree to pay for behavioral health services and other related clinical services according to the following fee agreement. I understand the following terms apply to this agreement:

- I agree to provide payment as follows (check one):

  _____ At the time of service

  _____ Within 2 weeks of receiving an invoice

  _____ Other (specify): _____

- I agree to the following fees for services (please initial each line). For more details, see Provider-Patient Agreement.

  _____ Initial Evaluation (60 min): ☐ $350.00 ☐ other: _____

  _____ 45-minute Treatment Session: ☐ $200.00 ☐ other: _____

  _____ Extended Treatment Session (prorated at the 45-minute rate). Amount: _____

  _____ Services related to disability claims. Amount: _____

  Description: _____

  _____ Electronic scoring of psychological/neuropsychological tests. Amount: _____

  _____ Other (specify): _____

  _____

- I agree to inform my provider as soon as I know if there are any changes in my ability to pay for services.
- I understand that services will be terminated if timely payment is not made as agreed upon by this Fee Agreement.

_____ _____

Patient Name (print) Provider Name (print)

_____ _____ _____ _____

Patient Signature Date Provider Signature Date

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