Acknowledgment of Financial Responsibility (Waiver) for Psychotherapy Treatment

Location | Date of Service

Patient Name | Date of Birth | Guarantor Name

I understand that payment for psychotherapy services provided by IHA are my (the patient or guardian's) responsibility. I also understand that deductible and copayments are due at each session and that I will be billed for services not reimbursed by my insurance company as outlined below.

Service	*Cost*
90832 Psychotherapy, 30 minutes with patient	$89.00
90834 Psychotherapy, 45 minutes with patient	$115.00
90837 Psychotherapy, 60 minutes with patient	$168.00
90839 Psychotherapy for crisis; first 60 minutes	$188.00
90840 Psychotherapy for crisis; each additional 30 minutes	$105.00

Self-Pay/Prompt Pay Discount

Self-Pay patients are eligible to receive a 25% discount from IHA Fee Screen. The discount will be applied off the full fee. Additionally, a 10% extra discount is available for payment at the time of service. The patient account will be designated as a Self-Pay, full charges will be entered, discounted payment will be calculated and collected at check out. Business Services will perform the applicable adjustments to the account.

- I have had this services explained to me, have read this form and understand it, have had the opportunity to ask questions, and had my questions fully addressed.
- I understand that I will be financially responsible for payment of all services provided that are not paid by my insurance company or that I have chosen to self pay.

Patient Signature | Printed Name | Date

Witness Signature | Printed Name | Date