CROSSROADS Behavioral Health

10 North Main Street ● West Hartford CT 06107 ● Tel: 860-233-8111 ● Fax: 860-236-2016

FINANCIAL AGREEMENT

I have voluntarily elected to enter into this financial agreement with Susan E. Peterman, Ph.D. at *Crossroads Behavioral Health,* this being my preferred way to pay for professional services. I do **not** wish for Dr. Peterman to bill any insurance companies on my behalf, and I understand that visits will **not** be submitted to my insurance company by Dr. Peterman retroactively. I will let Dr. Peterman know if I plan to submit claims to my insurance company, and will provide her with the necessary insurance information, and I understand that it is **my** responsibility to submit insurance clams on my behalf in a timely manner.

I understand that fees are due as stated and are payable in full at each visit. I agree to accept financial responsibility for any missed appointments without at least 24 hour notice, and I understand that cancellations must be made **by telephone only**. The missed appointment fee is the same as the full scheduled session fee.

I have carefully read the terms of the above guidelines and have had every opportunity to discuss any questions that I have. I fully understand all of the areas covered.

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(Date) (Signature)