Iristela Rodriguez, MA, LMFT
4502 Riverstone Blvd. Suite 1102
Missouri City, TX 77459
(281) 778-8750 Fax (281) 778-8751
Brightertomorrows01@gmail.com

Client Fee Agreement

Patient's Name:_____

Primary Health Insurance:_____
Benefit Coverage:_____
Deductible:_____ Co-Pay:_____

Secondary Health Insurance:_____
Benefit Coverage:_____
Deductible:_____ Co-Pay:_____

Self-Pay Agreement

_____Individual Counseling $100.00

_____Family or Couples Counseling $150.00 (for 75 min to 90 min)

_____I understand that payment for sessions is due at or before the beginning of each session. I agree that I am responsible for all charges for services provided by Iristela Rodriguez. I am agreeing to self-pay instead of using any insurance benefits I may have and I will not request in the future to file insurance claims for past sessions.

_____I understand that telephone or other consultations not specifically listed and lasting longer than 15 minutes may be billed at a prorated amount of the regular session fee.

_____Returned checks due to insufficient funds will have a charge fee of $35.00 in addition to the original fee and no checks will be accepted there after only cash or credit/debit cards.

_____Iristela Rodriguez reserves the right to seek recovery of any unsettled balances via collection agency or court settlement. In such cases, you shall be liable for any an all administrative and/or fees incurred.

I have read the above benefit information and certify that it is true to the best of my knowledge. I understand that by signing this document, I am responsible for services received with Iristela Rodriguez, LMFT. I further understand that I am responsible of notifying her of any insurance changes and for my co-payment or deductible.

Patient's Signature:_____Date:_____

Parent/Guardian's Signature:_____ Date:_____

Witness:_____Date:_____