Beyond the Brain Therapies, Inc./dba
Counseling and Mediation Solutions

The Brick House
407 West Broadway
Forest Lake, MN 55025

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Client Private Pay Agreement

I, the undersigned, understand that I am fully responsible for Counseling and/or Biofeedback services. At this time, I do not wish to utilize my insurance benefits to cover the costs of any fees incurred by me or my family members. **I also understand that I am expected to pay the private pay rate indicated below, before or at the time of the scheduled service**. I also understand that, if I should choose to utilize insurance, it is my obligation to provide coverage information and gain approval prior to the date of service.

I understand that I will be responsible for any and all unpaid amounts after insurance is applied. We agree to do our best to work with you. You understand that if there are overdue amount not being paid, that you will be legally responsible for all collection costs, reasonable attorney fees and all other expense incurred with collection if there is a default on this agreement.

I _____ (Health Practitioner) agree to a fee of $_____.

I understand and agree to the above terms of this agreement. Please note that we will work diligently to assist you in meeting your goals in a timely fashion. However, there are a variety of factors that go into this process and there is no way for the practitioner to know how many sessions will be needed to obtain your goals. Our commitment is to keep communicating and offering you the most effective and cutting edge therapies. We are committed to being cost and health conscious.

"Making Possibilities a Reality"

_____ _____

Client Signature or Guardian **Date of Agreement**

_____ _____

Client's Printed Name **Practitioner Signature of Agreement**

www.beyondthebraintherapies.com **www.counselingsolutionsmn.com**