Name of Client: ______________________________
DOB: ____________________________

Payment for Services

Noelle W. Clouse, LMHC
Clouse Counseling LLC
23 S. 8th Street, Ste. 200 Noblesville Phone: (317)-434-1738 noellewclouse@gmail.com

Cancellation Policy

I will be billed and held financially responsible for missed appointments without 24 hour notification. The missed appointment fee is $50.00 per session.

Service Fees*

Intake/Diagnostic Interview	(60 minutes)	$125.00
Individual Therapy Session	(30 minutes)	$100.00
Individual Therapy Session	(45 minutes)	$100.00
Individual Therapy Session	(60 minutes)	$100.00
Family Therapy Session	(45 minutes)	$100.00
Family Therapy Session	(60 minutes)	$100.00
Group Therapy Session	(60 minutes)	$30.00

*Sessions will be billed in accordance with the contractual agreement between the provider and the insurance company for consumers utilizing their medical benefits. All billing questions need to be presented in writing via email to the provider, who will, in turn, seek a response from the company's billing agency.

Authorization for Billing and Payment Owed

By signing, I acknowledge that I am financially responsible for all services rendered to me, my child, and/or my family, regardless of insurance benefits, if applicable. I am responsible for all bad debt, collection fees and costs associated with services for myself, my child, and/or my family. I agree to remit the designated fee for service/co-pay at each appointment. Accepted methods of payment include: cash, check, credit/debit card and HSA card.

I have read, understood and agree to the stated policies.

____ Date: __________
Signature of Parent/Guardian

____ Date: __________
Signature of Witness