WHITE OAK Counseling and Recovery
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Consent for Self-Pay Fee Sessions

Client's Name: _____

Initial Date of Service: _____ and all future appointments

Self-Pay Session Fee Rate: $_____per hour

I consent to pay the self-pay session fee rate for services rendered. I understand that these self-pay sessions are my responsibility and will not be billed to nor are the responsibilities of my medical insurance company.

_____ Initial I understand that I am responsible to pay for counseling on the same day as the counseling session is given. If payment is not received within 30 days, White Oak Counseling will bill my credit card on file, or if no credit card is on file, my account will be turned over to collections and the session rate will be increased to $170.00.

_____ Initial I understand that my Therapist does not participate with all or part of my insurance company. Therefore, I elect to:

☐ Pay the cash rate of $_____ towards either the deductible or copay*.

OR

☐ Be added to our Wait List for another Therapist who participates with my insurance.

*If deductibles are not met, the cash rate will reflect the amount required by your insurance company. If deductibles are met, this cash rate will reflect only the copay amount.

_____ Date: _____
Client/Parent/Guardian Signature

_____ Date: _____
Bret Hoxworth approval Signature