Megan Cronin Larson
A Vibrant Mind LLC

STATEMENT OF FEE POLICY

A Vibrant Mind LLC requests that you read and sign this statement to acknowledge your understanding of our policy. Your signature does not bind you to therapy; it does make you responsible for charges incurred.

Fees are payable to A Vibrant Mind LLC at the time of service.
A Vibrant Mind LLC accepts cash or check.

The fee for outpatient psychotherapy is offered $120 dollars **(50 min.)** if paying by check or cash. Under some circumstances, reduced fees are available.

Auxiliary services are prorated per 50 min. Auxiliary services refers to case summaries, school staffings, consulting with teacher/school, court evaluations, phone calls lasting longer than 15 minutes, court reports, and any other service **requested by the client.**

Emergencies: Clients seen in outpatient psychotherapy are assumed to be responsible for their day to day functioning. With this philosophy in mind, as your therapist I attempt to operate my practice in a way that is responsible to your needs, encouraging of your autonomy, and respectful to their limits. Therefore, I do not carry a pager and I am not ordinarily available for crisis calls that occur outside of scheduled appointments. **If you have a true emergency, call 911 or go to the nearest hospital.** However, exceptions to this policy will be made at this therapist's discretion as appropriate need arises. I check my voicemail messages regularly during business hours. Please leave your name and phone number. I will return your call when I am able.

Client Payment and Agreement

☐ I agree to pay in full at each session.

☐ I agree to be responsible for completing, filing & collecting third- party (e.g. insurance) reimbursement. A Professional Services Statement is completed at the end of each session and serves in lieu of the therapist filling out the "provider" section of the claims form. Simply attach this statement to your insurance form.

☐ I agree to give 24 hours notice when canceling or changing an appointment to have my fee waived.

☐ I agree to make full payment if I change or cancel an appointment without 24 hours notice.

_____ _____

Signature of Responsible Party Date