Dr. Vivian Sierra, LLC

Financial Agreement

Service Description	**Rates**
90791-diagnostic evaluation (first visit)	**150.00**
90834, 45 minutes-individual psychotherapy	**100.00**
90837, 60 minutes-individual psychotherapy	**130.00**
90846, 45 minutes-family psychotherapy, conjoint psychotherapy with the patient present	**130.00**
90846 , 45 minutes-family psychotherapy without the patient present	**125.00**
Phone sessions, per 15 minute increments	**35.00**
Other services outside of session time (e.g., letters or other preparation) , per 15 minute increments	**40.00**
Late cancellation or missed sessions (less than 48 hour notice)	**Contracted Rate** **$_____**

*Fees established March, 23, 2017, and are adjusted periodically.

I agree to the above fee schedule and understand payment (cash, check, or credit card) is due in full at the time of service and will include copays, deductibles, and coinsurance. I agree to pay a fee of $35.00 , in addition to the original check amount, for any returned checks.

I understand that the quote of benefits is not a guarantee of coverage or payment. I understand that payment of the benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service. I understand I am financially responsible for charges not covered by my insurance plan and/or EAP.

_____	_____	_____
Client Name (Printed)	Client Signature	Date
_____	_____	_____
Client Name (Printed)	Client Signature	Date
_____	_____	_____
Legal Guardian Name (Printed)	Legal Guardian Signature	Date