Leslie Edwards, MA, LPC, PLLC
Licensed Professional Counselor
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Private Pay Agreement

I, _____ (client name), by signing this agreement, indicate that I understand that my treatment with Leslie Edwards, MA, LPC, PLLC (provider name) beginning _____ (date), will not be covered by insurance because:

_____ I attest that I do not have insurance coverage for the services I am seeking
_____ I am choosing not to use my insurance coverage for my treatment. In doing so, I understand that I may not get the benefit of any provider discounts, and that my provider is not obligated to bill the plan. I understand that in doing so I waive any future right to bill insurance or be reimbursed by an insurance plan for sessions that have already taken place
_____ I have been notified by my provider or by the insurance plan that my treatment will not be covered by my health plan because:
  _____ It is not (or no longer) a covered benefit under my insurance plan
  _____ It is not (or no longer) covered because the plan has determined the treatment does not meet the plan's standards for medical necessity
  _____ This provider is not contracted with my insurance company; however, a superbill can be provided to determine if some portion of the services can be reimbursed

If this is the result of a decision by my health plan, I have been informed about the reason, am aware of my plan's formal appeal process, have elected not to appeal, or am in the process of appealing. In the meantime/instead I elect to continue therapy on an out-of-pocket basis, and I understand I will not be reimbursed by my insurance unless I am successful on appeal.

I agree that the provider may collect charges for the services at her full fee-for-service rate, or at the rates outlined below. I understand that insurance plan maximums will not apply and will not limit the amount I may become obligated to pay for the proposed services.

$_____ (amount) for _____ (type of services)
$_____ (amount) for _____ (type of services)
$_____ (amount) for _____ (type of services)

I understand that I have a right to a copy of this form. This consent is subject to revocation at any time except to the extent that action has been already taken in reliance thereon. By signing this agreement, I know that I am creating a binding contract that is legally enforceable against me by the provider.

_____ _____
Client signature (or responsible party) Date

_____ _____
Therapist signature Date