Janice Brown-Silveira, M.A. LLC
Licensed Marriage and Family Therapist
1325 Airmotive Way #175S Reno NV 89502
Phone: (775) 771-3866

Agreement to Pay for Professional Services

I request that Janice Brown-Silveira provide professional services to me or to _____, who is my _____, and I agree to pay the fee of $_____per session for future individual or family sessions. I understand that if I "no show" for an appointment I will be charged a fee of $50.00 for that session and that any insurance I have is unlikely to cover that fee. I understand that a "no show" is any session that is not canceled 24 hours in advance or by 4:00 PM Friday for a Monday appointment. Co-pays and/or co-insurance that is the member's responsibility is **due at time of service**. Payment needs to be made by check or cash. Credit or Debit cards are not accepted.

I agree that this financial relationship with Janice Brown-Silveira will continue as long as she provides services or until I inform her, in person or by certified mail that I wish to end it. I agree to meet with Janice Brown-Silveira at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by Janice Brown-Silveira although other persons or insurance companies may make payments on my (or this client's) account.

I have also read Janice Brown-Silveira's "Office Practices and Consent to Treatment" form and agree to act according to everything stated there, as shown by my signature below and on that form.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Janice Brown-Silveira, M.A. Date
Marriage and Family Therapist

Assignment of Benefits

I give this office permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. I understand that I am responsible for all charges, regardless of insurance coverage.

Assignment of benefits: I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Janice Brown-Silveira, MFT. A photocopy of this assignment is to be considered as good as the original.

_____ _____
Client's (or parent/guardian's) Signature Date

_____
Printed Name