Bonnie Triantafillos-Wright, LCSW-C
Rooting Through Grief, LLC
263 W. Patrick St., Mailbox #3
Frederick, MD 21701
301-524-0296

Client Name: _____

Client session rate is: _____

Copay (if applicable): _____

It is understood that:

1. If the client's insurance does not pay agreed fee, client is responsible for paying the balance.
2. If the client's insurance does not provide coverage for therapy as requested, the client understands that he/she will pay for sessions in full at the rate of $185/$160.

THE UNDERSIGNED HAS READ AND UNDERSTANDS THE ABOVE TERMS AND CONDITIONS.

Responsible Party: _____

Signature: _____

Date: _____