Full Cost Agreement

Date: ______________________

Client Name: ____ Case #: _____________________

I am not covered by medical insurance. I am requesting services from Recovery Technology LLC and ***I understand that I am responsible for the full cost of any services received***.

My insurance company does not participate with Recovery Technology LLC or does not cover the type of services I am receiving. ***I understand that I am responsible for the full cost of any services received***.

I understand that payment is due at the time services are received.

Service Fees

Group Therapy

$50.00 Intake
$25.00 Per Group Session
$30.00 BIP Workbook
$15.00 Anger Management Workbook

Individual Therapy

$112.50 Intake/Annual Assessment
$60.00 Per Individual Session

Case Management

$58.71 Per Unit (15 minutes)

Psychiatric

$150.00 Psychiatric Evaluation
$122.40 Medicine Review

____ ________________________
Client Signature Date

____ ________________________
Client Signature Date

____ ________________________
Guardian Signature Date

____ ________________________
Witness Signature Date