Western Psychological and Counseling Services
Cash Pay Agreement

I am choosing to make cash payments for the clinical services I receive at Western. I am doing this for the following reason(s):

- ☐ The services I am seeking are not covered by my health plan because they are not considered medically necessary (e.g., there is no covered diagnosis)
- ☐ The services I am seeking are not a covered service with my health plan (e.g., couple's therapy, family therapy outside of serving an identified patient with a covered condition, psychoeducation)
- ☐ I am choosing not to use my health plan benefits at this time (note: it is not possible to go back and use health plan benefits retroactively)
- ☐ The Western clinician who I would like to see is not a provider for my health plan
- ☐ I do not currently have insurance with mental health benefits
- ☐ I have Medicare and I am choosing not to use my Medicare benefits so that I can see a provider who is not a Medicare provider

My HOUSEHOLD annual income is: $_____ with _____ HOUSEHOLD members

Here are circumstances that would indicate a need for further discount: _____

_____

_____

I agree to the discounted fee per session of (complete only for the services being sought):

$ _____ for an Assessment/Evaluation

$ _____ for Individual Therapy

$ _____ for Group Therapy

$ _____ for Psychiatric Medication Evaluation & Management

This agreement pertains to services beginning ____/____/____ (date) and will remain in effect until a new written agreement is made. I agree to make cash payments at the time that services are rendered.

Client/Legal Guardian Signature: _____ Date: ___/___/_____

Client name (Please print): _____ DOB: ___/___/_____

Provider Signature: _____ Date: ___/___/_____

Provider name (Please print): _____