Questionnaire

* *indicates a required field*

* Client Name:

* DOB

* Insured Name:

PRIVATE PAY AGREEMENT

I understand that KATHLEEN ROMEIRO, LCSW is accepting me/my insured as a private pay psychotherapy client beginning the date that this consent form is signed, and I will be financially responsible for any services that I/my insured receive, including cancelation fees.

I have elected to pay out of pocket for all services and do not wish for my psychotherapist, KATHLEEN ROMEIRO, LCSW, to file a claim to my insurance carrier, now or in the future, if I have insurance.

I understand that I cannot retroactively seek monetary compensation for payments made, not now, nor in the future, in order to satisfy any deductible or out-of-pocket amount I may be subject to under the rules of my health insurance plan as a result of my decision to not initially use my insurance and/or gained insurance and did not inform my therapist.

I understand payment, according to my psychotherapist's payment structure for services provided to me/my insured in accordance to my treatment plan, is due in full at the time of service or the agreement is void.

* ☐ I consent to the Private Pay Agreement as documented above effective the start date of my treatment with Kathleen Romeiro, LCSW.

By checking this, you are eSigning this form.