CASH PAYMENT AGREEMENT
(For use with Medicare and commercial insurance)

PATHWAYS COUNSELING SOLUTIONS, PLLC

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

☐ I do not presently have insurance with mental health benefits.

☐ I have mental health benefits with ________________________ (Insurance Company) However:

- ☐ I have exhausted my current outpatient mental health benefits
- ☐ I am choosing not to use my insurance benefits at the present time.
- ☐ I wish to be treated by a PCS provider who is not a paneled member of my insurance network.
- ☐ My concerns are not covered by my insurance benefits or are not deemed medically necessary by my insurer.

☐ **I am choosing to schedule with a provider who is:**
NOT Medicare eligible (LPC, LMFT, CMHC, ALL CD PROVIDERS)
and am therefore waiving my use of Medicare and all other insurance(s) involved.

I agree to pay: $ ________ for my initial evaluation.

$ ________ for subsequent individual, couple, or family sessions.

$ ________ for group sessions.

$ ________ for follow-up medication management sessions.

This agreement pertains to services beginning __________ (date) and will remain in effect until such time as a new written agreement is made, or a valid insurance authorization is obtained and I consent for WPCS to bill my insurance. I agree to make cash payments at the time that services are rendered.

Client/Legal Guardian Signature: ________________________________ Date: ____________

Client Name (Please Print) _____________________________________

Provider Signature: _______________________________ Date: ________________