Don Baker, MA, LMHC
1836 Westlake Avenue N - Suite 303A
Seattle, Washington 98109
support@unpackingadhd.com
www.unpackingadhd.com

CLIENT PAYMENT AGREEMENT

I request that Don Baker, MA, LMHC, provide professional counseling services to me.

I / we agree to pay the fee of $185.00 for an initial diagnostic interview session, $175.00 per hour for psychotherapy or consultation services, $185.00 per hour for conjoint (couple / family) sessions.

I agree that this professional relationship and financial agreement with Don Baker, MA, LMHC will continue as long as he provides service, or until I inform him, either in person or by certified mail, that I wish to end this professional relationship. I agree to meet with Don Baker, MA, LMHC at least once before stopping psychotherapy services, in order to reach a mutual understanding of the basis for termination and to ensure appropriate psychotherapeutic closure. I understand that I/we will remain responsible for payment of the balance of fees accrued up to and including the final session, and agree to pay for all professional services provided to me / my family. In addition, I agree that by signing up for a set of group sessions, I agree to pay in full for all sessions regardless of my attendance.

I/we understand that while other persons or third party payers (e.g., insurance companies) may make payments on my / my family's account, I/we also understand and agree that I am/we are ultimately responsible for the charges incurred for the professional psychological services provided by Don Baker, MA, LMHC to me / my family.

I understand that if I/we do not cancel scheduled appointments with at least 24 hours notice. Don Baker, MA, LMHC reserves the right to bill me/us for this scheduled appointment time, at the above rates.

Signature of Client

Printed Name

Date

Signature of 2nd Client (if appropriate)

Printed Name

Date

Credit Card Authorization

I authorize Don Baker, MA, LMHC to charge the credit card listed below for any and all services provided to:

Name (as it appears on the card):

Credit Card Number:

Expiration: Month Year

CVV2 Code (3 or 4 digit code on front or back of card)

Billing Zip Code:

Please send a copy of the receipt to the following (choose one):

Email:

Phone (text message):

Note: Visa, MasterCard, American Express, Discover, PayPal, and HSA cards accepted.)

Using Your Insurance?

I am a preferred provider with Premera only. If you are covered by Premera and their subsidiaries, we will submit to your insurance. I'm considered "out-of-network" for all other carriers. Please note that it is your responsibility to know what your insurance benefits are.

I have provided a copy of the front and back of my current Premera or Regence insurance card to Don Baker, MA, LMHC Y / N

If Don Baker, MA, LMHC is an out-of-network provider for your insurance, please contact maryann@operationsplus.net / (253) 770-4703 option 2 for a copy of the receipt of charge(s) submitted to your insurance in order to submit for possible coverage.

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