

## Private Pay Agreement

Name of Patient:

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If applicable, Name of Parent/Guardian or person responsible for payment

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I understand that by signing this agreement, I indicate that I understand my/my child's treatment with Caroline Sabi, LPC is not covered directly by insurance because: Check on the box below and sign.

- I do not have insurance coverage for the service I am seeking.
- Caroline Sabi, LPC is not in-network with my insurance plan.
- I am choosing not to use my insurance coverage.
- I will be sending in the documentation for reimbursement but do not hold Caroline Sabi, LPC financially liable for such reimbursement.

Also, by signing this form, I agree that Caroline Sabi will be charging for the session upfront, on the day of the session at the agreed-upon amount. I also recognize that I do have a 72-hour cancellation policy for all appointments. I note that I will be given a superbill upon request but also note this is not a guarantee of reimbursement from the insurance company due to many factors out of the clinician's control.

By signing this form, I acknowledge the information contained above and agree. I consent to share the information provided here.

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