Psychological Counseling Services
7530 E. Angus Drive | Scottsdale, AZ 85251 | T 480.947.5739 | F 480.946.7795 | pcs@pcsearle.com | www.pcsearle.com

INTENSIVE PROGRAM AGREEMENT FORM

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Name of participant(s)

Deposits

A non-refundable deposit $1000 (U.S. Currency) *per week per participant* and a signed Intensive Program Agreement Form is required to activate scheduling of your intensive program.

For Emergency Services: For intensives scheduled within seven (7) days of the start date, a $2500 (U.S. Currency) non-refundable deposit *per participant* and a signed Intensive Program Agreement Form is required to activate scheduling of your program.

PCS accepts cash, personal check, Visa or MasterCard for non-refundable ***deposits only***.

Payments

(a) Intensive program services are cash programs and pre-payment is required. Payment in full is due at least seven (7) days prior to the beginning of each intensive week or by the due date indicated on your confirmation letter. The intensive coordinator will notify you of your schedule and the balance due. The cost of your program includes testing fees, supplies and administrative fees. ***PCS accepts wire transfers, cashiers checks or cash for balances due.***

(b) In the event that additional scheduling is done on an immediate and/or urgent basis, payment in full is required for the immediate and/or urgent additional services.

(c) In the event I schedule and pay in full for an intensive, I understand and accept the terms even if I choose not to receive services.

(d) In the event that the balance due is not paid by the Friday prior to your program, payment must be made at the front desk on Monday morning of your program and you will be assessed a $200 per week late fee.

By signing this section, I affirm that I understand and in agreement with this policy. ______________________

Sign here

Conditions/Definitions

(1) Any outstanding balances on my account(s) must be cleared prior to the beginning of the Intensive Program.

(2) Once you begin the program, there are no refunds. Should you or a therapist request sessions in addition to your schedule, we will do our best to accommodate you. No schedule changes can be made by the client(s) unless initiated by PCS. These add on session schedule changes must be paid for at the time the change is made.

(3) Please note that *once confirmation has been sent to you are responsible for payment in full* by the specified due date. This money will not be refunded to you for any reason within fourteen (14) days of your start date I accept these terms even if I choose not to receive services.

(4) A fourteen (14) day notice is required to reschedule your program and will incur a reschedule fee. Your program must be rescheduled within six (6) months of the original schedule date. If not scheduled within this time the program will be considered cancelled and the deposit will be forfeited.

By signing this section, I affirm that I understand and in agreement with this policy.

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Sign here

(5) Intensive Program Insurance Waiver and Agreement::

a) This office does not assume responsibility for billing an insurance carrier for Intensive Program services. Since intensives are cash programs, the patient is responsible for billing their insurance on their own, if they choose to do so. The patient is responsible for collecting the receipts. In the event this office inadvertently receives an insurance payment for these services, this office will redirect the payment back to the carrier and instruct them to pay the patient or insured directly.

b) The client(s) understand that they are responsible to obtain any pre-certification for Intensive services without the assistance of Psychological Counseling Services, Ltd, the professional staff members, or administrative staff members.

c) The client(s) understand that verification of benefits or pre-certification of services does not guarantee that an insurance carrier will cover this type of outpatient intensive services and the client(s) agree to pay for these services in advance.

(6) Information regarding participants:

1.____ ______________________________
Name Date of Birth Telephone contact number

2.____ ______________________________
Name Date of Birth Telephone contact number

Dates requested, please be specific: ______________________________ ________________________

(7) Each participant is required to sign and date this agreement form.

I/we agree to the terms and conditions outlined within this document.

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Print your name here **Sign your name here** **Today's Date**

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Print your name here **Sign your name here** **Today's Date**

If making the deposit by Visa or Mastercard, please complete the following:

□ Visa Card Account Number______________________________ Expires ________ CID #_______

□ Master Card Account Number______________________________ Expires _______ CID #_______

Name on card ___________________________________

(Please note that if card does not belong to client we will need an Authorization Form completed by client and a Credit Card Agreement Form completed by cardholder)

If you are faxing back to PCS, please fax to the confidential fax number 480-946-7795.