

PRIVATE PAY AGREEMENT FOR THERAPY SERVICES

I, _____, agree to pay for therapy services rendered by the **Mary Lee Foundation Rehabilitation Center** as indicated below.

SERVICES TO BE RECEIVED:

____ Occupational Therapy ____ Speech Therapy ____ Physical Therapy
____ Case Management

PAYMENT

____ Payment will be made with cash or check (made out to the Mary Lee Foundation Rehab Center)

____ Please check below for your preferred method of billing (select either address or email address)

○ **Address:** _____

○ **Email address:** _____

OUR POLICY (please initial to acknowledge understanding)

___ Cost is \$75.00 per hour of skilled therapy (PT, OT, OR ST)

___ Cost is \$50.00 per hour of case management services

___ We require a 24 hour cancellation notice, failure to provide notice will result in being charged a missed fee of \$50

___ Payment receipts will be sent to either the email or physical address provided above

___ Payment is due within 14 days of invoice receipt

By signing below, you agree to the terms and conditions outlined above.

Signature of Client

Today's date

Signature of Payor (if different than client)

Today's date