RESTORATIVE WELLNESS

## CONTRACTED AGREEMENT

Date:_____

This agreement is between _____(Client) and Santa J. Crisall,

RN, MA, APN-BC, PsyD (Provider) for services rendered .

This agreement acknowledges that _____(Client) will:

- Patients must provide proof of insurance prior to services rendered, or be considered self-pay.
- Self-pay patients are responsible for paying the entire amount in full at completion of service.
- Provide required insurance co-payment at onset of session in cash or check to Provider;
    - Acceptable forms of payment such as cash or personal checks
- Notify Provider 24 hours in advance of anticipated cancellation of an appointment
- If notification of cancellation is not within 24 hours by client, Provider will bill Client for the cancelled appointment
- Complete HIPPA Service Agreement form

Thank you,

*Santa J. Crisall*

Santa J. Crisall, RN, APN-BC, MA, PsyD

*Provider*