JANUARY MASSIN, PH.D.

Licensed Clinical Psychologist (NYS License # 019588)

81 Irving Place, Suite 1B

New York, NY 10003

FINANCIAL AGREEMENT

I, _____, have requested treatment from January Massin, Ph.D. I have read and currently understand the following:

1. I bill after each session. Appointments must be canceled or rescheduled at least 24 hours in advance of the scheduled time. Appointments that are not canceled within this timeframe will be billed. I charge for all sessions that are missed without notice.

2. I am responsible for all payments, which must be made at the time of service. I understand that my provider is not participating in any insurance plans. I understand that I may, in a separate statement give my provider permission to communicate with my insurance company if my insurance plan reimburses me for out-of-network benefits.

3. If I chose to request reimbursement from my health insurance company for out-of-network services, I understand that I must provide my health insurance carrier information in a timely fashion so that the claim may be paid. I understand that benefits are not determined by my insurance carrier until after my claim is submitted; therefore, there is no guarantee of payment of by my insurance carrier. If my insurance carrier denies reimbursement, that in no way affects my financial obligation to January Massin, Ph.D.

4. A denied credit card/check from a financial institution is subject to fees if applies.

Patient Signature: _____

Date: _____