Jane C. Woodward, LICSW

2 Franklin St.
Exeter, NH 03833
(603) 312-1206

Reimbursement Agreement

Client Name _____

I agree that Jane will bill my insurance company _____,
and I will pay my copay/deductible/coinsurance at the time of each visit.
The charge for the most common services are as follows:

Intake (first session): $150.00
Individual therapy, 45 minutes: 110.00
Individual Therapy, 60 minutes: $140.00
Interactive Complexity add on: $15.00 per face to face session
Crisis Evaluation: $200.00

If Jane makes reasonable efforts to obtain authorization from the insurance company, but they then do not pay, I will assume responsibility for the entire bill.

There is a $40.00 charge for missed appointments with less than 24 hours notice. No shows incur the full fee of $110.00.

Insurance ID# _____

Insurance Phone Number _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber Employer _____

Subscriber Home Phone # _____
Address _____
_____
_____

Client/Guardian Signature _____Date _____