



PeaceWay CMS

Counseling & Mediation Services, Inc.

Agreement To Treatment

PeaceWay Counseling & Mediation Services, Inc. (PCMS) staff is dedicated to providing quality professional counseling services and treatment. PCMS hosts an integrity driven team of professional therapist that specializes in diverse areas of counseling.

Office hours are Mondays, Wednesdays, and Fridays from 9:00 a.m. to 6:00 p.m. and Tuesdays and Thursdays from 9:00 a.m. to 7:00 p.m. and Saturdays by appointment only. If you have an emergency situation, please call our office first and explain the situation to a staff member. ***If office is closed, please dial 911.***

We will file your insurance plans; thusly a copy of your insurance card is required upon sign in. Any amount unpaid by the insurance will be your responsibility. You are required to pay any co-payment and/or deductible at the time your service is rendered. If, for any reason, your insurance company cannot be contacted or will not give authorization to us for the necessary information needed for treatment services to begin, you will be required to pay the bill and we will file your insurance for you.

If your insurance company does not pay within 45 days, we will ask you to pay the amount and/or balance due for services rendered. Please keep your account current.

We accept money orders and cashier's checks. Payment is due at the appointment time. If you cannot keep a scheduled appointment, you must give at least 24 hours notice. Failure to show up for an appointment or failure to cancel your appointment within 24 hours will result in you being charged the full amount of the session. These charges will be billed to the client and not the insurance company. Charges for missed appointments are determined by the services that you are scheduled to receive.

If you are late for your appointment, you may have to be rescheduled. Late arrivals after 15 minutes will be rescheduled or the time spent may have to be reduced. You may be charged for a missed appointment if this occurs. You will be responsible for any charges that the insurance company will not cover regarding a late arrival, late cancellation, or missed appointments.

I have read ALL of the above policies or had the above polices read to me. I understand them & agree to them.

Client Name: _____ Date: ____/____/____

Date of Birth: ____/____/____ Social Security Number: ____/____/____

Signature of Client or Guardian _____

If Guardian what relationship: _____ Date: ____/____/____

Signature of PCMS Staff reviewing policies _____

Date: ____/____/____