Agreement for Service / Informed Consent

This agreement has been created for the purpose of outlining the terms and conditions of services to be provided by technician for _____ (herein "Client") and is intended to provide important information regarding practices, policies and procedures of technician, and to clarify the terms of the professional therapeutic relationship between technician and client.

I understand that the intended purpose of biofeedback training is for relaxation and muscle reeducation so I may learn to: 1) reduce my stress, 2) manage my pain, and/or 3) improve the quality of my life. I understand that biofeedback training is considered safe. I further understand that biofeedback is not a substitute for effective standard medical, chiropractic or psychotherapy treatment. Vista Mental Health has advised me to continue ongoing medical treatment and therapies until otherwise advised by my medical physician or medical practitioner. I further understand it is my responsibility to ask my medical doctor for permission to undergo biofeedback training if I wear a peacemaker or have any medical condition that may be exacerbated by relaxation. I understand it is my responsibility to monitor the effects of biofeedback training and to continue the training for as long as it is beneficial to me. I further understand that research suggests that while most people gain considerable benefits from quantum biofeedback training, I understand there is no guarantee that it will.

Patient/Guardian Signature _____Date_____

Patient/Guardian Printed Name_____

Insurance Benefits and Patient Responsibilities for Fees

We do not participate as a contracted provider for any insurance companies, but can provide you with a superbill (a detailed receipt of services provided) that you may submit to your insurance company. They may or may not provide some direct reimbursement to you. Payment is due at the time the service is rendered. We accept cash, check, and major credit cards. It is required that a credit card be kept on file. This card will be charged the **full fee for failure to keep any scheduled appointments without 24 hours prior notification** (or one business day- so in the case of weekends and holidays, cancellations will need to be made more than 24 hours in advance) and will also be used to when billing for phone calls. Phone calls longer than ten minutes may be charged as a full session. Any outstanding fees will be charged to the card designated on this form.

CPT	DESCRIPTION OF PROCEDURE	MINUTES	FEE
90901	Biofeedback	50	$125
	Biofeedback (practice session)	25	$65

Forms/letters: $50-$200 (Variable/time dependent) Insufficient funds/returned check fee: $50

I understand and accept the terms of the charges, cancellation fees, insufficient funds/ returned check fees and no-show policy as outlined above and authorize Vista Mental Health (or Dr. Deborah Fein Medical Corp) to charge my credit card or checking account accordingly.

Name on Card:_____

Card #_____

Expiration date: _____ Security code: _____

OR

Name on account: _____

Account#: _____ Routing#: _____

Phone number associated with account: _____

Billing street address:_____

City: _____ State: _____ Zip:_____

Signature: _____ Date