

Pauline Jarakian M.S. MFT

1102 Sanchez St. San Francisco, Ca. 94114

415 246-4117

**Financial Responsibility Agreement, Fees,
Cancellation Policy and Consent to Disclose
Information to Insurance Carrier.**

I agree to pay Pauline Jarakian MFT, her established fee for therapy services at the time of service. This fee was agreed upon with initial contact by phone before setting up an appointment. If I use my insurance benefits, I will pay the co-payment each time service is rendered. In the event that my insurance company fails to pay Pauline Jarakian for services, I am responsible to cover any outstanding balance.

Signature of Patient

Date

Signature of Therapist

Date

I consent to permit, Pauline Jarakian MFT to disclose patient related information for purposes of obtaining payment and sessions with client's insurance company.

Signature of Patient

Date

I am required to give Pauline Jarakian MFT, 24 hours of notice prior to canceling an appointment. I will do this by phone. If I fail to do so, I am responsible for full payment of the session. I agree to comply with this.

Signature of Patient

Date