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**Financial Agreement**

Thank you for choosing Shades of Wellness, LLC services for your needs. Please read and sign the agreement below. It lays out our billing, scheduling and cancellation procedures. If you have any questions, please ask for clarification.

Shades of Wellness, LLC is a fee for service practice, and we do not accept any private insurance. It is your responsibility to call your insurance to verify your reimbursement coverage for the services we provide. We are happy to assist you in any way we can. If your insurance requires additional information, please let us know how we can help. If you would like some additional assistance on how to verify your coverage, please let us know; we have available a sample insurance verification questionnaire which may assist you further. I hereby understand:

* Services are NOT covered by insurance therefore payment of all fees is expected at the time of booking a credit card/debit on file.
* I hereby authorize payment(s) to be deducted from my banking account or flexible spending account directly to SHADES OF WELLNESS, LLC for all services rendered where applicable.
* I will be responsible to pay a $60 late cancel fee for any missed or cancelled initial visits, not made at least 24 hours in advance prior to the scheduled appointment time.
* If I default on my account, I understand I will be subject to finance and/or legal fees in addition to the total account balance.

**Print Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_