

**ANN BOYER HOLMES, MSW**  
PSYCHOTHERAPIST

5675 STONE ROAD, SUITE 320  
CENTREVILLE, VA 20120  
703 623 7441

**Office Policies and Financial Agreement**

Please read the following statements and sign your name below. I will be glad to discuss any policy with you or answer any question before signing. Upon request, a copy of this agreement will be provided for your records.

Payment in full is to be made when services are rendered. Payment may be in the form of cash, money order, or personal check. Checks are payable to *Ann Boyer Holmes*. A statement of services and payments will be provided at the time of service upon request.

As a pre-licensed therapist I do not participate with any insurance companies. Since every insurance company and policy is different you should check with your insurance carrier to determine if any part of these services are reimbursable. In addition, a statement of services and payments can be provided upon request for your own medical records or for a health savings account disbursement.

Checks returned for insufficient funds are subject to a \$35.00 processing fee.

All services are provided on an appointment basis. This time will be held for you and is not available for other patients. It is your responsibility to inform me if you will not be keeping an appointment. At least twenty-four (24) hours advance notice is required to cancel an appointment without charge. If I am able to reschedule within the next 7 days, you will not be charged for the missed session. If I cancel your appointment, you will not be charged for the session.

A copy of the HIPAA (Health Information Portability and Accountability Act) compliance policy is available on request from the office manager or can be seen at [www.fairfaxmentalhealth.com](http://www.fairfaxmentalhealth.com). I will be happy to answer any questions you may have about my privacy and confidentiality policy.

Please note that Fairfax Mental Health is not a partnership. Each professional in this office is an independent provider and shares no responsibility or liability for the advice given to the undersigned unless requested to render a service.

I have read, accept, and agree to the above.

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Patient's Printed Name

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Patient's Signature

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Date