CLIENT INFO & FINANCIAL RESPONSIBILITY AGREEMENT

It is the policy of Mirashift Therapy, PLLC that payment is due at the time of service unless other financial arrangements are made in advance.

INSURANCE

Although Mirashift Therapy, PLLC is considered an out of network provider with insurance carriers, our therapy services may or may not be covered by your particular insurance plan. Referrals to our clinic by other therapists or a physician doesn't guarantee your insurance carrier will cover our services. Please remember that you are 100% responsible for all charges incurred. Please check with your insurance carrier for coverage of CranialSacral therapy, as we are unable to file for you.

RATES

First visit initial consultation fee is $30.
Current rates are $150 for a full session and $80 for half session.

PAYMENTS

We accept Zelle, Cash, MasterCard, Visa and American Express.

SLIDING SCALE

Mirashift will not turn away a client in serious need of therapy, for inability to pay. We continue to offer sliding scale rates for special needs when appropriate. Our commitment to serving the community remains a high priority, so don't hesitate to request a consultation to discuss your particular needs.

SCHEDULING

We have been fortunate to have consistent therapy and maintenance clientele and will continue to support scheduling up to 8 weeks in advance. Please keep this in mind with our limited hours of operation so we can help you maintain your preferred day and time for future appointments.

CANCELATIONS

Due to client waitlists, we kindly ask that you give as much notice as possible for rescheduling and canceling. Please note our policy below:

- Appointments canceled less than 48 hours to scheduled treatment will be charged 50% of the entire session booked.
- Appointments canceled less than 24 hours to scheduled treatment will be charged 50% of the entire session booked.

I understand and agree that the fees charged for professional time or services are not disputable or refundable. By signing this agreement and the correspondence check or credit card receipt for the rendered service or time, I accept the financial responsibility for the charges, and I am waiving any claims to the charges.

Printed Name _____ Date _____