Client Financial and Fee Agreement

SERVICE	FEE
Initial and Readmission Evaluation/Diagnostic Assessment	**$150.00**
Individual Psychotherapy session (45-50 minutes)	**$135.00**
Couples/Family Therapy (75 minutes)	**$180.00**
Administrative work on client's behalf	**$50.00 per quarter hour**
Late cancellation (less than 24 hrs) or missed appointment	**$75.00 - no exceptions**

Your insurance or EAP will be billed at the above rates.

Due to insurance carriers' occasional delays in processing claims submitted by providers, please read the following:

____If your insurance company does not respond to therapist in a timely fashion, a Statement will be sent to you. Upon receipt of the Statement, Please contact your insurance carrier and request that they process your claim.

____Should you receive any correspondence from your insurance company regarding the services in this office, **you must respond to that correspondence immediately**, in order to have that claim processed and paid. If a claim is denied payment by your insurance company, you, the client will be responsible for the balance owed at the therapist's full session rate or your insurance company's rate contracted with therapist.

____Please remember that insurance or EAP is considered a **method of reimbursing client fees** to the provider and is not a substitute for payment. Some insurances pay a fixed allowance for certain procedures, and others pay a percentage of the charge. ***It is the client's responsibility* to *1. Verify eligibility and coverage,*** *2. pay any deductible amount, co-insurance, or any other balance not paid by your insurance at the*time of service. 3. If applicable, to monitor remaining funds in their FSA/HSA accounts.

___Fees may be paid with **cash or check**.

Client's or authorized person's signature: I authorize the release of any mental health or other information necessary to process any insurance claim.
Insured's or authorized person's signature: I authorize the insurance payment of mental health benefits directly to the provider for services. I fully understand that, regardless of the insurance coverage, I am legally responsible for all fees due the provider.

***Returned checks** will be assessed a $30 office fee, the provider's bank fee and the amount of the check. If this occurs it may be necessary for the therapist to require cash payment for subsequent sessions.*

Co-payments, co-insurance, or self pay session fees** are expected at the time of service. Please do not ask for an exception. The therapist will not carry a balance due to insurance non-payment longer than 30 days. At that point, therapist may postpone therapy until payment is secured unless doing so would cause immediate harm to the client. **Please call your insurance MEMBER SERVICES # to determine deductible, coinsurance, copay information.

Signature:_____Date: _____