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)	**$175.00**
Administrative work on client's behalf	**$50.00 per quarter hour**
Late cancellation (less than 24 hrs) or missed appointment	**$75.00**

Your insurance/EAP will be billed at the above rates. ***Note:*** ***EAP*** *sessions are reimbursed to the therapist directly and clients will not be asked for a co-pay. These are also the Self pay 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, I suggest that you then 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 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 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 your responsibility*** **to** ***1. Verify eligibility and coverage, and deductible, 2. Pay any deductible amount, co-insurance, co-pay or any balance not paid by your insurance at the time of service. 3. To monitor your deductible and inform therapist when met.***

___ Fees may be paid with cash or check. If credit card, a processing fee of up to 4.6% will be charged in addition to session fee.

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 $30 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.**

Signature: _____ Date: _____