

Agreement to Pay for Professional Services

We are committed to providing you with the best possible care.

Unless otherwise agreed to by you and your therapist, sessions are billed as follows:

\$150 for an initial assessment; \$120 for a 50 minute individual, marital or family session; \$150 for a 70-90 minute individual, marital or family session; and \$50 for a 60 minute group therapy session. With the exception of brief phone contacts, you will be billed for phone therapy, emails or other professional services (including assessments and letters to outside professionals, extended coordination of care with other professionals) at the rate of \$120 per hour. You will be informed of any services requiring additional payment before the services are rendered. You may request a receipt to submit to your insurance company for any covered service.

Insurance Reimbursement

We participate with a number of insurance plans. We would be happy to submit the documentation to your insurance company at no additional cost. Most insurance plans have a deductible and/or session copayment that is your responsibility. We require these payments at the end of each session. You are also responsible for any fees not covered or not paid by your insurance company. Please contact your insurance company to determine your benefits and authorization requirements. If your insurance company requires a pre-authorization, please have the required information with you at the first session.

No Show and Late Cancellation Policies

Please give us at least 24 hours notice of cancellation of your appointment. You will be billed at the same rate as your normal session fee for not giving a minimum of 24 hours notice. This fee is your responsibility and will not be billed to your insurance company. It must be paid prior to additional psychotherapy services being delivered.

Payment

Payment for services is due at the time of service. We accept cash, checks, MasterCard, Visa and Discover. If you would like your credit card to be charged for your payments, please provide the information on the Pre-Authorized Health Care Form. You will be provided with a receipt for payments.

Accounts left delinquent more than 90 days may result in your account being turned over to IC Systems, our professional collection service. Late fees or interest may accrue for late payments.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client) although other persons or insurance companies may make payments on my (or this client's) account.

Signature of client (or person acting for client)

Date