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**BILLING POLICY**  
**FEES:**

<b>Initial Assessment</b>	<b>\$175</b>
<b>Individual Session</b>	<b>\$150 (50 minutes)</b>
	<b>*\$25 (for each additional 15 minutes after 60)</b>
	<b>\$100 (30 minutes)</b>
<b>GROUP</b>	<b>\$125 (90 minutes)</b>

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**RESPONSIBILITIES:**

All charges are the responsibility of the client. Insurance is a reimbursement of charges made for services as a convenience to our clients, and the client is ultimately responsible for all charges incurred as a client of this agency.

**INSURANCE:**

It is the client's responsibility to know their insurance coverage and to be current with insurance benefits.

**TESTIFYING IN COURT:**

Clients are charged \$150 per hour for time in court, travel time to court, and consultation/preparation with their attorney.

**PSYCHIATRIC & MEDICAL EVALUATION/CONSULTATIONS:**

Psychiatric & Medical Consultations are needed if medication or illness is part of the treatment plan or if psychiatric/medical input would be helpful in assessment or treatment. This charge is further explained under PAYMENT PLANS.

**WRITTEN REPORTS & LETTERS:**

If the client and therapist agree that a letter or written report from the therapist is required to coordinate care with other providers or to assist in any legal proceedings, the client is charged \$100 per hour. Insurance does not cover these fees.

**CANCELLATION:**

Clients are charged full fee for a "no-show" to an appointment unless there are mitigating circumstances. No charge is made if the appointments are cancelled 24 hours prior to scheduled appointment. Insurance does not cover these fees.

**TELEPHONE:**

Client is charged \$20 for every 15 minutes of conversation, plus long distance charges (where applicable).

**SELF PAY:**

Payment (by cash, check, or credit/debit card) is required at the time of service. Returned checks' funds are subject to a \$35 fee.

**FINANCIAL HARDSHIP:**

In the case of financial hardship, my therapist and I have agreed to an alternate payment plan: Fee per session: \_\_\_\_\_

**In the case that I am financially unable to take care of my account, my personal guarantor for my account is:**

\_\_\_\_\_  
**(Name)**

\_\_\_\_\_  
**(Address)**

\_\_\_\_\_  
**(Phone)**

**COLLECTION AGENCY:**

Past-due accounts will be turned over to our Collection Agency. All fees incurred because of this action become the responsibility of the client.

\*I/We understand and agree to the above administrative policies.

\*In the case of insurance coverage, I/we agree to pay the deductible and/or any co-pay amounts.

\_\_\_\_\_  
Client &/or Guardian Signature

\_\_\_\_\_  
Date