PATHWAYS
COUNSELING CENTER

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2020

BILLING POLICY

FEES:

Initial Assessment	**$200**
Individual and/or FAMILY SESSION	**$100 (30 minutes)**
	$145 (45 minutes)
	$180 (60 minutes)
	***$50 (for each additional 15 minutes after 60)**
GROUP	**$120 (90 minutes)**

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 $180 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 $180 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 $25 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**