PATHWAYS
COUNSELING CENTER

11121 W. Oklahoma Ave
West Allis, WI, 53227
P (262) 754-5912
F (262) 641-9791

PATRICIA CONNORS, LCSW **2020**

BILLING POLICY
FEE SCHEDULE:

Initial Assessment:	**$200.00 (60 minutes)**
Individual/Family Session	**$165.00 (60minutes)**
Individual/Family Session	**$140.00 (45minutes)**
Individual/Family Session	**$100.00 (30 minutes)**
Group	**$120.00 (90 minutes)**
Written Reports	**$175.00/Report**

- 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,
- It is the client's responsibility to know his/her insurance coverage and to be current with insurance benefits. Please note that all deductibles and co-pays are payable at the time of the session.
- If your insurance does not cover 100% of the charges, we ask that you begin paying your share of the fees when therapy begins. If special payment arrangements are needed, e.g., a monthly payment plan, please speak to the billing office or your therapist.
- Clients are charged a fee for a "no show" appointment unless there are mitigating circumstances. There will be no charge if appointments are cancelled 24 hours prior to scheduled appointment. Insurance does not cover these fees so please make every effort to cancel appointments in a timely manner.
- Reports or letters written to health care providers or other professionals are billed at $60.00 per hour, with a minimum charge of $25.00. These charges are not covered by insurance and must be paid before the report will be released.
- If you are a self-pay client, the fee is payable at the time of service. We accept cash, checks, or credit cards (Master Card and VISA).
- In the case of financial hardship, my therapist and I have agreed to an alternate payment plan as herein described: _____

  Fee per session: $ _____.
- Past due accounts will be turned over to our Collection Department. All fees incurred because of this action become the responsibility of the client.
- In the case of a returned check for non-sufficient funds, there will be a $35.00 fee.

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

_____ _____ _____

(Name) **(Address)** **(Phone)**

*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