PATHWAYS
COUNSELING CENTER

11121 W. OKLAHOMA AVE
WEST ALLIS, WI, 53227
P (262) 754-5924
F (262) 641-9791

MEGAN GONZALEZ, MSCP, LPC-IT
pathmgonzalez@gmail.com

JANUARY 2020

BILLING POLICY
FEE SCHEDULE:

Initial Assessment	**$200**
Individual/Family Session	**$100 (30 minutes)**
Individual/Family Session	**$160 (45 minutes)**
Individual/Family Session	**$180 (60 minutes)**
	$50 (for each additional 15 minutes after 60)
Group	**$90 (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.

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, there will be a fee of $50 charged. Insurance does not cover these fees.

TELEPHONE:
Client is charged $25 every 1 minute of conversation, plus long-distance charges (where applicable).

CANCELLATION:
Clients can be charged the full fee for a "no-show" for an appointment unless there are mitigating circumstances. No charge is made if appointments are cancelled 24 hour prior to the scheduled appointment. Insurance does not cover these fees so please make every effort to cancel appointments in a timely manner.

SELF PAY:
Charges to the client are payable at the time of service. Cash, check, and credit cards are accepted. Returned checks 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: $_____ 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 Number)**

COLLECTION AGENCY:
Past due accounts will be turned over to our Collection Agency. All of the fees incurred because of this action will 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**