11121 W. Oklahoma Ave
West Allis, WI, 53227
P (262) 641-9790
F (262) 641-9791

Chesney Limas, MS, LMFT
chesneyklimas@gmail.com

2020

BILLING POLICY
FEES:

Initial assessment	**$200**
Individual, Couples, Family session	**$180 (60 minutes)**
	$140 (45-50 minutes)
	$100 (30 minutes)
	$ 45 (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. If your insurance has a deductible or copay, please promptly make your payment at the time of your session. If you are unable to pay at this time, it is your responsibility to notify your therapist.

WRITTEN REPORTS & LETTERS
Clients are charged $115 per hour for written reports and letters. These fees are not covered by insurance.

CANCELLATION
Clients are charge the full fee of $140 for a "no-show" appointment unless there are mitigating circumstances, as determined by the therapist. Insurance does not cover these fees. No charge is made if appointments are cancelled 24 hours prior to the scheduled appointment. If a client cancels and/or "no-shows" appointments for 3 executive sessions, it can result in termination of treatment and a list of referral counselors will be provided for you via mail or email.

TELEPHONE
Client is charged $25 for every 10 minutes of conversation, plus long-distance charges where applicable.

SELF-PAY
Payment is due at the time of service. We accept cash, checks, and credit cards. 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 of:
$_______ 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) (Date)

COLLECTION AGENCY
Past due accounts will be turned over to our Collection Agency. All fees incurred because of this action will become the responsibility of the client. Returned checks for non-sufficient funds are subject to a $35 fee.

*I/We understand and agree to the above administrative policies of Pathways Counseling Center.
*In the case of insurance coverage, I/We agree to pay the deductible and/or copay amounts.

Client and/or Guardian Signature **Date**
~~~~~~