PATHWAYS
COUNSELING CENTER

11121 W Oklahoma Ave
West Allis, WI 53227
P (262) 754-5913
F (262) 641-9791

STEVIE J. MILLER, MS, LMFT
smiller@pathwayscounseling.com

FEBRUARY 2021

BILLING POLICY FEE SCHEDULE

Initial Assessment	$200.00	(55 minutes)
Individual and/or Family Session	$180.00	(55 minutes)
Individual and/or Family Session (**no insurance**)	$150.00	(55 minutes)
Individual and/or Family Session	$145.00	(45 minutes)
Individual and/or Family Session	$100.00	(30 minutes)
	$50 (each additional 15 minutes)	
Group	$120.00	(90 minutes)
Group (**no insurance**)	$65.00	(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 co-pay, please pay at the time of the appointment.

CANCELLATION:
Clients will be charged **full fee** for a "no show" appointment unless there are mitigating circumstances. No charge is made if appointments are cancelled 24 hours prior to scheduled appointment. Insurance does not cover these fees. **After 3 "no show" appointments, clients will be removed from therapist's schedule and must be in contact with therapist in order to schedule any future appointments.**

TELEPHONE:
Client is charged $50.00 every 15 minutes of conversation plus long distance charges where applicable.

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 $180.00 per hour. Insurance does not cover these fees.

OUT OF OFFICE MEETINGS/COURT:
Travel time to meetings/court out of the office are billed $100/hr. Meetings/court time are billed at the office rate of $180/hr. Insurance does not cover these fees.

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: $_____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 clients.

***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 and/or Guardian Signature **Date**