PATHWAYS
COUNSELING CENTER

11121 W. Oklahoma Ave
West Allis, WI, 53227
P (262) 754-5915
F (262) 641-9791

ROGER NORTHWAY, MS, LCSW **JANUARY 2020**

BILLING POLICY
FEE SCHEDULE:

Initial Assessment:	**$200.00 (55 minutes)**
Individual/Family Session	**$175.00 (55minutes)**
Individual/Family Session	**$140.00 (45minutes)**
Group	**$ 95.00 (90 minutes)**

***Extended sessions will have a prorated charge**

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 can be charged the 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 so please make every effort to cancel appointments in a timely manner. This includes scheduled group therapy sessions.

TELEPHONE:
Client is charged $50.00 every 15 minutes of conversation plus long distance charges where applicable. This charge is not covered by insurance.

OUT OF OFFICE MEETINGS/COURT:
Travel time to meetings/court out of the office are billed at $100 per hour. This fee is not covered by insurance. Meetings/court time is billed at the office rate of $175 per hour.

WRITTEN REPORTS/LETTERS:
Client is charged for all written reports. Treatment Progress/Compliance Reports are at minimal one report but can exceed six reports as requested. Reports will not be released until payment is received.

SELF PAY:
Balances are payable at the time of service. Cash, check and credit are accepted.

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 will become the responsibility of the clients. In the case of a returned check for non-sufficient funds, there will be a $50.00 fee.

***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**