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**2020**

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**BILLING POLICY**

**FEES:**

<b>INITIAL ASSESSMENT</b>	<b>\$150</b>
<b>INDIVIDUAL AND/OR FAMILY SESSION</b>	<b>\$75 (30 minutes)</b>
	<b>\$135 (45 minutes)</b>
	<b>\$150 (60 minutes)</b>
	<b>\$25 (for each additional 15 mins after 60)</b>
<b>GROUP</b>	<b>\$120</b>

**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.

**PSYCHIATRIC & MEDICAL EVALUATION/CONSULTATIONS:**

Psychiatric & medical consultations are needed if medication or illness is part of the treatment plan or if psychiatric/medical input would be helpful in assessment or treatment. This charge is further explained under PAYMENT PLANS.

**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 \$150 per hour. Insurance does not cover these fees.

**CANCELLATION:**

Clients are 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.

**TELEPHONE:**

Client is charged \$25 for every 15 minutes of conversation, plus long-distance charges (where applicable).

**SELF PAY:**

Payment is required at the time of service. Cash, checks and credit cards are accepted. 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: Fee per session \$ \_\_\_\_\_

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

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(Name)	(Address)	(Phone number)
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**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.

\*I/We understand and agree to the above administrative policies of Pathways Counseling Center.

\*I/We agree to pay the deductible and any amount my insurance does not cover.

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Client Signature	Date
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