PATHWAYS
COUNSELING CENTER

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BILLING POLICY
FEE SCHEDULE:

Initial Assessment:	**$180 (55 minutes)**
Individual/Family Session	**$160 (60 minutes)**
Individual/Family Session	**$145 (45 minutes)**
Individual/Family Session	**$120 (30 minutes)**
Group	**$100 (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 the insurance benefits. If your insurance has a deductible or copay, please pay at the time of the appointment.

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. Written materials will not be released until payment is received.

OUT OF THE OFFICE MEETINGS/COURT:
Travel time to meetings/court out of the office are billed at $100 per hour. Meetings/court time is billed at the office rate of $150 per hour. Insurance does not cover these fees.

TELEPHONE:
The client is charged $50 for every 15 minutes of conversation, plus long-distance charges (where applicable). This charge is not covered by insurance.

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 hours prior to the 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.

SELF PAY:
Charges are payable at the time of service. Cash, check, and credit 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 pay 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 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 copay amounts.**

_____

Client and/or Guardian Signature **Date**