PATHWAYS
COUNSELING CENTER

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2021

BILLING POLICY
FEE SCHEDULE:

Initial Assessment:	**$200.00**	**(55 minutes)**
Individual/Family Session	**$180.00**	**(55 minutes)**
Individual/Family Session	**$165.00**	**(45 minutes)**
Individual/Family Session	**$145.00**	**(30 minutes)**
Group	**$120.00**	**(90 minutes)**

RESPONSIBILITIES:
Client is responsible for paying the agreed upon amount for services provided in a timely manner. Failure to pay your bill or failure to make a payment arrangement resulting in a balance of over $300 may result in termination of treatment. In the event of nonpayment, we reserve the right to utilize a collection agency or other legal means. 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 his/her 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.

WRITTEN REPORTS and 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 $100.00 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/hr. This fee is not covered by insurance. Meetings/court time is billed at the office rate $150/hr.

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

CANCELLATION:
Clients can 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 so please make every effort to cancel appointments in a timely manner. This includes scheduled group therapy sessions.

SELF PAY:
Payable at the time of service. Cash, check and credit accepted. Returned checks subject to a $35.00 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 &/or Guardian Signature **Date**