PATHWAYS
COUNSELING CENTER

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**2021**

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## BILLING POLICY

**FEES:**

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| **Initial Assessment** | **$200** |
| **Individual and/or FAMILY SESSION** | **$100 (30 minutes)** |
| | **$145 (45 minutes)** |
| | **$180 (60 minutes)** |
| | ***$50 (for each additional 15 minutes after 60)** |
| **GROUP** | **$120(90 minutes)** |
| ***No Insurance** | **$60 (45 minutes)** |
| ***Group/Family Session** | **$45(90 minutes)/$125 (60 minutes)** |

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**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.**

**TESTIFYING IN COURT:**
**Clients are charged $180 per hour for time in court, travel time to court, and consultation/preparation with their attorney.**

**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 $180 per hour. Insurance does not cover these fees.**

**CANCELLATION:**
**Clients are charged full fee for a "no-show" to an appointment unless there are mitigating circumstances. After 3 consecutive no show sessions, you will be dropped from caseload. No charge is made if the 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 (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: Fee 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 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 co-pay amounts.**

_____ _____
**Client &/or Guardian Signature** **Date**