Financial and Payment Information

Therapy sessions are billed at $175.00 per hour *(in 15 minutes increments)*. **PLEASE GIVE 24 HOURS NOTIFICATION OF CANCELLATION OF APPOINTMENT.** Failing to notify the clinic or to show for a session may result in full charges being billed directly to you for the missed session. Full payment is collected at each session (check, cash or credit card) unless previous arrangements have been made or insurance preauthorization has been secured. In these cases only the co-pay will be collected.

If you wish to review your records or obtain copies of records, please notify your therapist. You may request for any reason a meeting or consultation with the Clinic Director. If you wish to file a grievance, notify the Clinic Director or your therapist and a copy of the procedure and necessary forms will be provided.

Telephone Consultations: The basic purpose of a telephone consultation is for rescheduling appointments or answering brief questions. For some people an extended phone consultation is preferred to an office appointment. All telephone contacts over 10 minutes will be charged at a rate of $45 per 15 minute increment; partial increments will be billed in full. Please note that insurance may not cover such telephone consultations.

Retainers: In certain cases it is necessary for the therapist to coordinate/consult with lawyers, do observation in school, write extensive reports and perform testing and other non direct therapy work as a part of treatment. Where these types of activities are anticipated an initial retainer of at least $500.00 will be collected at the beginning of service to cover such costs. The unused portion will be refunded at the end of service.

Reports and Record Reviews: When reports or reviews are requested and authorized by you for the court, schools, physicians, lawyers, or other purposes, the time to prepare and produce such documents will be charged at a $75.00 per half hour rate.

Identity Verification: As a medical provider, we are required by Federal law to verify the identity of our clients by photo ID at the start of service in order to prevent Medical Identity Theft. Drivers Lic.________Photo ID_______Other(Specify)_______________

FINANCIAL AGREEMENT

I understand that I am responsible for payment in full of all charges incurred. I agree to pay the standard fee rate and any balance due over and above what my insurance will pay for services rendered.

I have read the above information and it has been explained to me by the co-signing therapist. I hereby consent to treatment which includes *(please check all that apply):*

_____Individual Therapy

_____Group Therapy

_____Couples Therapy

_____Family Therapy

_____Other *(specify):*

____

Client(s) Signature *Date*

Therapist Signature *Date*

2/2014