



FEE AGREEMENT

FEE FOR SERVICES

We understand that unless another payment schedule is specifically arranged (see last page of this form), the following fee agreement applies: The charge for individual, couple, and family psychotherapy is \$100.00 per 50-minute session or \$150.00 per 80-minute session. The fee for group psychotherapy is \$35.00 per session.

PAYMENT AGREEMENT

We understand that if we are paying privately we will pay for all services provided for ourselves, (client names) _____, at the conclusion of each session on the day the services are provided.

We understand that if we are not able to honor our financial commitment that this may be grounds for conversing therapeutically about financial issues, renegotiating our therapeutic contract, exploring alternative options, and/or terminating from treatment.

We understand that if we are not able to make a payment after a particular session that we may ask our therapist for an extension for another week. We agree to make every effort to remit payment within that time frame. We also understand that we may not have more than **two** unpaid sessions accumulated at any one time. If this should happen we understand that we will need to speak with our therapist in order to negotiate the next steps.

We understand that we may pay with cash, personal checks, money orders, or credit card, however, should our personal check be returned due to insufficient funds, we will be assessed a \$20.00 service charge and we will be requested to pay with cash, money order, or credit card thereafter. We realize that while our signature does not bind me to therapy, it does make me responsible for all charges incurred prior to our termination.

Finally, we release *Connexus Counseling Center, LLC* and our therapist from all liability for providing to a Collection Agency any information necessary to collect fees due if our account becomes delinquent and that should this happen, the cost for collection will become our responsibility.

MISSED SESSION POLICY

We understand that our full fee will be charged for any missed appointments or appointments canceled with less than 24 hours notice without just cause (i.e. an emergency, inclement weather, etc).

We understand that most third party payment sources, such as insurance companies and victim compensation, do not pay for missed sessions and thus we are solely responsible for these fees.

LIMITATIONS OF CONFIDENTIALITY

We understand that if we are providing payment for a non-minor designee, we may not have legal access to any kind of privileged information about that individual including assessment information, diagnostic information, or therapeutic progress. By contrast, we do understand that if another party, such as an insurance company, is providing payment for our therapeutic services, we authorize that individual or institution to be informed of our presence in treatment, details of our diagnoses and care, and/or our discharge from treatment. We also understand that there are further limitations to confidentiality discussed in the *Client Disclosure Statement* or other agreements and are aware of these constraints.

USING INSURANCE OR THIRD PARTY PAYMENT SOURCE

We understand that if we are using insurance or another type of third party payment source that we authorize *Connexus Counseling Center, LLC* to release and/or exchange any pertinent information with

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INDIVIDUALS, COUPLES, AND FAMILIES

such entities in order to utilize these benefits. This information includes but is not limited to our presence in treatment, our progress in treatment, our psychiatric diagnosis, any assessment information, and our discharge plan.

In addition, we also agree to pay our designated co-pay or co-insurance and to promptly and consistently communicate with such entities if our situation should change in order to ensure that our coverage is continuous. We understand that most third party payment sources, such as insurance companies, do not pay for missed sessions and thus we are solely responsible for these fees. We further recognize that it is our responsibility to obtain any pertinent information about the following in order to utilize these benefits:

- *Types and amounts of coverage (For example, is marriage/couple counseling covered under your plan?)*
- *Annual deductible amounts (Sometimes your co-payment amount or other type of coverage does not go into effect until you pay an annual deductible)*
- *Requirements for pre-authorization if necessary (Does your plan require you to have pre-authorization before services will be covered?)*
- *The types of forms or paperwork that we, or our therapist, need to complete and/or remit in order to receive reimbursement.*

REVISIONS TO FEE SCHEDULE

\$_____ Fee for Individual Psychotherapy, Couple, or Family Therapy
(50-minute session minimum; longer sessions will be prorated based on this amount)

\$_____ Fee for Group Psychotherapy

\$_____ Other: _____

Client/We have read the preceding information and we agree to the aforementioned terms:

Client Name #1: _____

Client Signature: _____ Date: _____

Client Name #2: _____

Client Signature: _____ Date: _____

Therapist/Witness: _____ Date: _____

- NOTE: Only complete if the client is NOT the individual responsible for payment -

Payee/I have read the preceding information and I agree to the aforementioned terms:

Payee Name: _____

Payee Signature: _____ Date: _____

Therapist/Witness: _____ Date: _____

Revised: 11/2/09