



## **FEE AGREEMENT**

### **FEE FOR SERVICES**

I 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**

I understand that if I am paying privately I will pay for all services provided for myself (or for my designee), (client name) \_\_\_\_\_, (relationship \_\_\_\_\_,) at the conclusion of each session on the day the services are provided.

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

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

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

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

### **MISSED SESSION POLICY**

I understand that my 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).

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

### **LIMITATIONS OF CONFIDENTIALITY**

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

### **USING INSURANCE OR THIRD PARTY PAYMENT SOURCE**

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



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

In addition, I also agree to pay my designated co-pay or co-insurance and to promptly and consistently communicate with such entities if my situation should change in order to ensure that my coverage is continuous. I understand that most third party payment sources, such as insurance companies, do not pay for missed sessions and thus I am solely responsible for these fees. I further recognize that it is my 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 I, or my 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/I have read the preceding information and I agree to the aforementioned terms:**

Client Name: \_\_\_\_\_

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: \_\_\_\_\_