

**FEE AGREEMENT AND FINANCIAL POLICY**

Thank you for choosing Believe Counseling and Consulting Inc. Please review this Fee Agreement and Financial Policy (the “Agreement and Policy”), which describes our schedule of fees for services, charges not covered by insurance, and additional fees. Please be sure you understand the policies regarding cancelations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. If you have any questions about anything, **please ask your provider prior to signing this Agreement and Policy**.

**Our service rates and corresponding health insurance billing codes (numbers starting with ‘90’ refer to mental health services).** This is not a comprehensive list and reflects the most common services provided by our staff. Additional codes may be used by your provider as deemed appropriate.

• 90791 Initial Consultation – Individual (50-60 min.) $180.00

• 90837 Individual Therapy (60 min.) $155.00

• 90834 Brief Individual Therapy (45 min.) $140.00

• 90832 Brief Individual Therapy (30 min.) $110.00

**CHARGES NOT COVERED BY INSURANCE**

* Medical Records Requests -1st request free, subsequent $15.00 per request
* Court Reports - $100
* Private Pay by clinical level staff (Not billed to insurance) $100/hour
* Private Pay by masters level staff (Not billed to insurance) $50/hour

**ADDITIONAL FEES**

* Late cancelations/Missed Appointment – fewer than 24 hrs. prior to appointment $35.00
* Past-due accounts – over 90 days $25.00 per month
* Checks returned due to insufficient funds will incur a fee of $45.00

**PAYMENT**

* You will be expected to pay for either each session in full, or your insurance co-payment at the time of services. If you are unsure of your insurance benefits, a deposit of $50 will be taken. Accepted methods of payment are cash, check, credit cards or Health Savings Account debit cards. Checks should be made payable to *Believe Counseling and Consulting, Inc.*

**INSURANCE REIMBURSEMENT**

Believe Counseling and Consulting, Inc accepts and process insurance payments through a variety of insurance providers and Employee Assistance plans. If you are using insurance or Employee Assistance provider to pay for our services, then we will:

(1) Expect and accept payment of your copayment amount at the time of service;

(2) File your claim with the insurance provider

(3) Receive payment from your insurance provider

4. ***Expect that you will pay your portion due of copay, co-insurance, deductible, or fee difference at the time of your appointment.***

**PLEASE NOTE**

***Believe Counseling and Consulting, Inc files insurance as a courtesy to you, and that you (not your insurance company) are ultimately responsible for your bill.*** If your insurance company denies a claim filed on your behalf, then you are responsible to pay Believe Counseling and Consulting Inc for the difference between the standard rate and the amount previously paid as copay unless approved otherwise by owners of Believe Counseling and Consulting Inc

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I agree to (1) allow Believe Counseling and Consulting Inc to bill my insurance directly for services provided under the Treatment Agreement; (2) give Believe Counseling and Consulting Inc permission to release any information the insurance company may require in order to process payment; appoint Believe Counseling and Consulting Inc as my authorized representative to act for me in obtaining payment; (3) assign all of my rights to claims and payment by my insurance to Believe Counseling and Consulting Inc; and (4) agree to assist with the claims

process as required by Believe Counseling and Consulting Inc or my insurance provider. I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies.

**Patient name (printed)\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Private/Self-Payment for Services**

**I will self-pay for services at Believe Counseling and Consulting Inc. Private pay rates are provided at a discounted rate of $100/hour and will not be filed with insurance by Believe Counseling and Consulting Inc. I understand that payment for services is due at the time services are provided.**

**Patient name (printed)\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CANCELATIONS & MISSED APPOINTMENTS**

Insurance carriers will not pay for late cancelations or missed appointments. Once an appointment is scheduled, that time is reserved specifically for you. Cancelations must be made at least 24 hours in advance. Although 24 hours is the minimum, if you need to cancel or reschedule please give as much notice as possible. You may notify our office of cancelation by phone or email to your provider. Late cancelations (fewer than 24 hours before the appointment) will incur a fee of $35.00. Exceptions will be at the discretion of Believe Counseling and Consulting Inc.

**PAST DUE ACCOUNTS**

Because your treatment is our first priority, we encourage you to talk with us about any financial hardships you may be having. We are willing to work with you in regards to co-pays and payment plans so we do not disrupt your current therapy schedule. As such, you will receive a monthly statement to assist you in keeping track of your financial obligations. We believe that communication is important and we want to be completely transparent with you regarding your bill.

Amounts past due by more than 90 days will incur a late fee each month of $25.00. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, Believe Counseling and Consulting Inc may resort to legal means to secure payment. This may involve hiring a collection agency, an attorney or going through small claims court. If such legal action is necessary, you will be responsible for those costs.

**Patient name (printed)\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***I have read the Agreement and Policy above, and I have been offered a copy for my records. I understand the policy and by my signature below I agree to be bound by its terms in association with outpatient services provided to me by Believe Counseling and Consulting Inc. Any and all negotiated exceptions or special arrangements are listed below and require approval and are not valid unless signed by a representative of Believe Counseling and Consulting.***

Patient name (printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**I understand financial statements will be sent monthly. My preferred method of receiving these statements is**

\_\_\_\_\_via USPS mail. My preferred address to receive this is:

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\_\_\_\_\_via email. My preferred email to receive this is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_