FEE AGREEMENT AND FINANCIAL POLICY

Thank you for choosing The Rock Counseling Group. 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.) $200.00
- 90837 Individual Therapy (60 min.) $175.00
- 90834 Brief Individual Therapy (45 min.) $130.00
- 90832 Brief Individual Therapy (30 min.) $100.00
- 90847 Couples Therapy* (60 min.) $175.00

CHARGES NOT COVERED BY INSURANCE

- Medical Records Requests $15.00 per request
- Case Management* $130.00 (pro-rated per 15 min.)
  Case Management includes indirect services I provide outside our session times such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), coordinating adjunct and Court Advocacy services, and completing forms or reports. On occasion you may request that we testify or be present in court proceedings on your behalf of subpoena from the court the time billed will begin from our arrival at the courthouse to completion of testimony.
- Phone Consultations (11-60 min.) $130.00 (pro-rated per 15 min.)

ADDITIONAL FEES

- Late cancelations/Missed Appointment – fewer than 24 hrs. prior to appointment $35.00
- Non-sufficient funds (bounced) check $25.00
- Past-due accounts – over 30 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 provided under the ***Outpatient Services Agreement***, which will be given to you along with this Agreement and Policy and our ***Notice of Privacy Practices***. Accepted methods of payment are cash, check, or credit cards. Checks should be made payable to *The Rock Counseling Group.*

INSURANCE REIMBURSEMENT

The Rock Counseling Group 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

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

I agree to (1) allow The Rock Counseling Group to bill my insurance directly for services provided under the Outpatient Services Agreement; (2) give The Rock Counseling Group permission to release any information the insurance company may require in order to process payment; appoint The Rock Counseling Group 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 The Rock Counseling Group; and (4) agree to assist with the claims process as required by The Rock Counseling Group 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)_____

Patient /Guardian signature:_____

Private/Self-Payment for Services

I will self-pay for services at The Rock Counseling Group. I agree to the fee schedule in this document. I understand that payment for services is due at the time services are provided.

Patient name (printed)_____

Patient /Guardian signature:_____

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.

PAST DUE ACCOUNTS

Amounts past due by more than 30 days will incur a late fee each month of $25.00. If your account has not been paid for more than 45 days and arrangements for payment have not been agreed upon, The Rock Counseling Group 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)_____

Patient /Guardian signature:_____

CREDIT CARD ON FILE

Upon scheduling your first appointment you have the option to provide credit card information which will be kept on file to be used as a form of payment for fees incurred for co-pays, co-insurance, deductibles, late cancelations, missed appointments, returned checks, or past due account balances.. A receipt will be e-mailed to you at the address you specify below at your request or by email .

Type of card (circle one):

☐Visa MasterCard ☐American ☐Express Discover

Card # 16 Digits:____ ____ ____ ____- ____ ____ ____ ____ -____ ____ ____ ____-____ ____ ____ ____

Expiration: _____

Security code:_____

Name on card: Initial here: _____

I authorize The Rock Counseling Group to charge this credit card as needed according to the terms specified in this Agreement and Policy.

Signature: _____Date: _____

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 The Rock Counseling Group. Any and all negotiated exceptions or special arrangements are listed below and require approval and are not valid unless signed by a representative of The Rock Counseling Group.

Patient name (printed)_____

Patient /Guardian signature:_____