DARING MINDS
therapy

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# BILLING POLICIES

The fees for services will be provided accordance with the reasonable value set forth by the established community guidelines and standards. Daring Minds Therapy, LLC's billing policies for their current providers are as follows:

Sarah M. Worley, LIMHP, Erica R. Schroeder, LIMHP, & Stephen Capecci, LIMHP services are charged as follows:

90791- Intake $250.00, 90847-Family session $180.00, 90834-Individual session $160.00, 90832- ½ hour Individual session $110.00, 90837- Extended Individual session $245.00, 90846- Session without patients present $170.00, 90853-Group session $60.00. Co-Occurring Evaluation (Self-Pay)- $320, Substance Use Evaluation (Self-pay) $170, Mental Health Evaluation (self-pay) $170. Any reports requested, client will be billed $100.00 per hour.

Kiki Haakenstad, LMHP services charged as follows:
90791- Intake $250.00, 90847-Family session $180.00, 90834-Individual session $160.00, 90832- ½ hour Individual session $110.00, 90837- Extended Individual session $245.00, 90846- Session without patients present $170.00, 90853-Group session $60.00. Any reports requested, client will be billed $100.00 per hour.

Maureen DeRyke, PLMHP, PMSW, Bethany Mahan, PLMHP, Robyn Vanderveen, PLMHP, & Amber Pace, PLMHP services charged as follows:

90791- Intake $180.00, 90847-Family session $120.00, 90834-Individual session $100.00, 90832- ½ hour Individual session $50.00, 90837- Extended Individual session $170.00, 90846- Session without patients present $160.00, 90853-Group session $60.00. Any reports requested, client will be billed $100.00 per hour.

No Show Fee / Less than 24-hour Cancellation Fee $75

I understand that I am liable ultimately for the balance on my account for any services provided by Daring Minds Therapy, LLC/ Sarah M. Worley, LIMHP, Erica R. Schroeder, LIMHP, Stephen Capecci, LIMHP / Kiki Haakenstad, LMHP / Maureen DeRyke, PLMHP, PMSW, Bethany Mahan, PLMHP, Robyn Vanderveen, PLMHP, Amber Pace, PLMHP regardless of the status of my insurance situation. With my signature, I agree to adhere to the agency's billing policies and procedures, and to pay any fees that I owe the agency based upon such policies. I hereby authorize direct payment and all benefits due under my insurance policy to Daring Minds Therapy, LLC for services provided. I authorize the release of medical or other protected health information necessary to process insurance claims.

Printed Name: _____ Date: _____

Signature: _____