4851 CR 135 McMillan, MI 49853
(906) 235-6750 Phone (844) 241-2634 Fax
trilliumwoodcounselingservices@gmail.com
https://trilliumwoodcounselingservices.com/

TRILLIUMWOOD COUNSELING SERVICES FEE AGREEMENT

Client Name_____ **Date**_____

I understand:

- **I am seeking psychotherapy services at Trilliumwood Counseling Services.**
- **If using insurance, I am responsible for deductibles and co-payments.**
- **I am responsible to pay for services not covered by insurance.**
- ***I need to bring my copay to each session (call provider for copay amount).***
- **If I fail to provide 24 hour notification for missed appointment (MA) I will be responsible for $40 fee, 2nd MA $80 dollar fee and 3rd (MA) full rate $130 with termination of services**

Trilliumwood Counseling Services Private Pay Rates

Initial Intake/Assessment 135$
Psychotherapy 16-37 min $65
Psychotherapy 38-52 $90
Psychotherapy +53min $130
Family with Client +26min $110
Dispositions, Testimony, and other Court Proceedings $200/hour
Psychological and **Substance Abuse Assessment**/Evaluation **$300**
The rate billed may be adjusted based on your insurance provider agreements

Option A: No Insurance or sliding fee scale – I agree to pay $_____per session based on aforementioned/above session rates.
Option B: Insurance Coverage – I agree to pay any deductible based on my insurance policies.
Option C: Federal, State, County or other Human Service Agency Contracts – I agree to pay any portion as required by said agency per hour/session. Session number limited based on contract.
Option D: Referral from Employee Assistance Program (EAP) – I understand that my EAP covered services are to be paid for by my employer. Session number limited based on employer contract.
Option E: Other Payment Plan - _____

My signature indicates I understand this fee agreement and that I will pay the appropriate fees. I authorize release of all records required for billing purposes, and request authorized benefits be made on my behalf to Timothy A.E. Fillmore MS, LMSW (DBA) Trilliumwood Counseling Services for all services covered by my insurance.

_____

Client Signature **Date**

_____

CPT Timothy A.E. Fillmore MS LMSW BCD **Date**

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