Counseling Associates of Rockford

Counseling Associates Patient Financial Policy

Payment Policy: Co-payments, coinsurance, and all deductibles are due at each session.

Cancellations and Failed Appointments: There will be no charge for cancellations made at least 24 hours prior to the scheduled appointment. Failure to keep an appointment or give at least 24 hours notice of cancellation will result in a $50 charge. This fee is not reimbursable by insurance and therefore will not be billed to insurance.

Emergencies: Patients are expected to be responsible for their own well-being and able to function autonomously between sessions. As a therapist in private practice, your therapist cannot assume responsibility for patient's day-to-day functioning, as can institutions such as hospitals and mental health centers. New patients need to discuss any expectations of after-hours care with the therapist during the initial appointment so that an appropriate referral can be made.

Termination: The therapist has the right to terminate therapy and be paid for accrued fees if the patient fails to cooperate fully in the counseling or to pay in a timely manner. If the patient wishes to terminate this agreement, he or she is still responsible for paying all accrued fees.

Additional Professional Services/Fees: These include report writing, telephone conversations, consulting with other professionals with consent, preparation of records, legal court proceedings, transportation, and/or other legal involvement. Fees depend on the service and are available upon request.

Collection Fee Agreement: If this account is placed with a collection agency for non-payment, for collection or any subsequent legal action, there will be an additional collection fee of 30% of the account balance due, as well as any attorney fees and court costs incurred and permitted by laws governing these transactions.

Client Agreement: By signing this document, the patient agrees to all professional policies. The patient understands that there can be no absolute cure in the practice of psychotherapy.

_____ _____

Patient Signature Date

_____ _____

Guardian Signature (if patient is a minor) Date

_____ _____

Signature of Provider Date

6975 REDANSA DRIVE ROCKFORD, IL 61108 815.398.7000