



Sandra Olshak, LCSW

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## Service Agreement and Informed Consent

**Fee:** The full fee for services *prior to insurance coverage* is \$125 for an initial diagnostic appointment and \$100 an individual therapy session. *Your out-of-pocket fee is based on the contracted rate set by your insurance company.*

**Appointments:** The initial appointment will last 60 minutes and subsequent appointments will last 50-55 minutes. *In order to accommodate your scheduling needs and preferences, as well as those of my other clients, I have a strictly enforced policy related to late cancellation, late arrival and missed appointments.*

**Late Cancellation:** I require 24 hours advance notice to change or cancel an appointment. Unexpected issues arise that may result in your need to cancel your appointment with less than 24 hours notice. The first late cancellation (with less than 24 hours advanced notice) will result in a \$25 charge to your account regardless of the reason for the cancellation. Any subsequent late cancellations will result in a charge equal to the full fee for a 45-minute session (\$80.00).

**Same-day Cancellation/Missed Appointments:** An \$80 no show fee will be charged for any appointment missed without calling to cancel in advance. If you arrive for your session more than 15 minutes late, you will need to reschedule and will be charged for a missed appointment. If you call to cancel within 2 hours of your scheduled appointment, it will be regarded as a missed appointment and you will be charged accordingly.

*Any no show or late cancellation fees **must be paid in advance** of scheduling the next appointment unless other arrangements have been made. For your convenience, a link to pay no show fees will be sent to the email address that I have on file any time you have accrued a balance on your account.*

**Insurance:** You are responsible for contacting your insurance carrier to check on your coverage for outpatient mental health care. I can submit a bill to your insurance company if you plan to use your insurance. I can also provide you with a billing statement at the end of each month upon your request for submission to your insurance company if you would prefer to pay for the session in full. You are responsible for the full amount of any claims that are denied due to issues with your coverage, including unmet deductible amounts.

**Payment:** Any out of pocket cost (i.e. co-pay) is **required at the time of the session** unless prior arrangements have been made. **I am able to accept cash (exact change only),**

**personal check, HSA card or credit/debit card.** Any outstanding bill will be discussed and services may be interrupted until the issue is resolved. I do reserve the right to seek legal means to secure reimbursement, up to and including providing your name and address to a collection agency, an attorney, and/or a court of law.

**Confidentiality:** Information about your participation in services is confidential and cannot be released without your written permission unless you are threatening harm to yourself or others, or you disclose the abuse of a child or vulnerable adult, which I must legally report to authorities. Your clinical record can also be turned over to a court of law in response to a legitimate subpoena.

**Emergencies:** In the event of a life-threatening emergency, please call 911 or go to the nearest emergency room. In the event of an urgent matter, please contact the Brazos Valley Mental Health (MHMR) 24-hour crisis line at 888-522-8262.

***By signing, I agree to these terms and conditions and give permission for insurance claims to be filed on my behalf.***

**Client/Guardian**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_