LIGHTHOUSE COUNSELING SERVICES
"BRINGING HOPE AND DIRECTION DURING STORMY TIMES"

FEES: Fees are due at the time of service. My fee for service is $180--$120. I am on many major insurance companies and I am happy to bill the appropriate insurance company. Checks should be made out to Lighthouse Counseling Services (LCS) or John Lucas. Debit cards and credit cards
(Visa, Mastercard, American Express, Discover) are accepted for your convenience. Fees are subject to change.

NON-INSURANCE: Non-insurance clients may have more time added to their sessions at the rate of 25$ for every 15 min of therapy if scheduling permits.

EXTRAS: Phone conversations are free. Phone sessions are the same cost as therapy. Anything requested in writing is $20/first page and $10/subsequent pages. Any copy of notes to the client or professionals is .50 cents a page. Any faxing of notes and information is .50 cents a page.

INSURANCE: If you have insurance you are responsible for any co-pays or deductible payments at the time of service. If you are not eligible for insurance coverage at the time services are rendered, you are responsible for the payment.

LATE CANCELLATIONS / NO SHOWS: Your session time is 45-60 minutes and has been reserved for you. If you are unable to keep the appointment, please contact us 24 hours in advance. It is understandable that things come up last minute, however, the session will be lost revenue so I hope you can understand requiring some compensation. Late cancellations will be charged at $20. All no call/no shows will be charged at 30$.

LEGAL ISSUES: Should I appear in court on your behalf for any reason or be required to give my time for any legal issue, the cost for my services (including travel time) is my regular fee of 150$ per hour.

OUTSTANDING CLIENT BALANCES: There will be a 3% charge on outstanding balances every 60 days past due that are the patient's responsibility apart from expected insurance reimbursements. This charge can be deferred by a payment plan agreed upon by both parties.

RESPONSIBLE PARTY: If the person responsible for payment is different than the patient please provide their information.

Name_____

Address_____

Phone_____

I allow the therapist to release any information to the responsible party regarding payment and finances.

Signature: _____Date: _____