Heal Together Counseling
Financial Responsibility Agreement

If you are using an insurance plan, please know that fees are paid at a contracted rate and may differ from the rates listed below. Additionally, not all services are covered by insurance. It is the client/legal representative's responsibility to know/understand the coverage of their insurance plan.

Services Offered:

60 Minute Initial Intake Assessment…………………………………………….………$175.00

60 Minute (53 – 60 minutes) Individual Therapy……………………………………$150.00

45 Minute (38 – 52 minutes) Individual/Family Therapy…..………………………$125.00

30 Minute (16 – 37 minutes) Individual/Family Therapy…………………………..$75.00

Offsite Meetings with third party participants………………………..…………$150.00/hr

- **This service is not typically covered by insurance**

Virtual Meetings with third party participants……………………………………...$50.00/hr

- **This service is not typically covered by insurance**

Court Fees………………………………………………………………………………$200.00/hr
Court fees include all requested court appearances, travel to the courthouse, preparation and documentation time.

- **This fee is not typically covered by insurance**

Late/No Show Fees…………………………………………………………………...$Full Rate

- **This fee is not typically covered by insurance**

Returned checks/Declined payment (credit cards) Fee…………..……….$25.00

- **This fee is not typically covered by insurance**

Payment Balance Fee……………………………………………………………….$25.00
This fee will be incurred every 30 days from the original date of service until the balance is paid in full unless payment plan was discussed in advance.

- **This fee is not typically covered by insurance**

Financial Policies

- I understand that all fees are to be paid, in full, at the time of the appointment, unless alternative arrangements have been made with the therapist. __________ (initial)

- I acknowledge and accept that I am fully responsible for paying any charges incurred should my insurance company not cover services that were provided to me. It is my responsibility to notify my therapist of any insurance changes prior to my next appointment. _________ (initial)

- I understand ALL cancellations require a minimum of 24 hours of notice prior to the scheduled appointment. Insurance companies do not cover the fees for late cancellations/no show appointments. Payment will be the responsibility of the client. __________ (initial)

- I understand that an active credit card is required to be kept on file to pay for services rendered, fees and balances. __________ (initial)

- I authorize that my credit card can be processed for charges related to services including copays, deductibles, full session payments, no show/late cancellation fees, late payment fees. __________ (initial)

- Should I default in part or all of my financial responsibilities to pay, I understand that my name, address, telephone number, dates of service and balance owed will be disclosed to a collection agency. I authorize the release of this information for the purpose of payment collection. __________ (initial)

- I understand that there may be late fees associated with my balance if payment is not made on-time. Late fees are $25 for every 30 days the balance remains unpaid from the date of service. I am responsible for all late fees. __________ (initial)

- I understand that a $25 fee will be incurred for any returned checks. ____________ (initial)

Release of Information for Insurance Reimbursement

I authorize the following information to be released to my insurance company for the purpose of reimbursement: name, diagnosis, dates of service, date of onset, progress updates, treatment plans, therapist name and other requested information.

I have read this agreement. I have had the opportunity to ask questions and have had them answered to my satisfaction. By signing, I acknowledge an understanding and agreement to the conditions as outlined above.

Financial Responsibility Agreement & Policies

By signing below, I acknowledge that I have read and understand the fees associated with the above listed services and agree to the terms as outlined.

______________________________	______________________________
Client Name	Date of Birth
______________________________	______________________________
Parent/Guardian Name	Therapist: Rebecca Searles, LICSW
______________________________	______________________________
Client/Parent/Guardian Signature	Date