Heal Together Counseling, LLC
194A Pleasant Street, Suite 206
Concord, NH 03301
Phone: 401-584-4325
Fax: 978-616-7325

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/guardian's responsibility to know/understand the coverage of their insurance plan. Any unpaid expenses are the responsibility of the client/parent.

Services Offered:

Initial Intake Assessment…….……$150.00

60 Minute (53 – 60 minutes) Individual Therapy…….$125.00

45 Minute (38 – 52 minutes) Individual/Family Therapy…..……$105.00

30 Minute (16 – 37 minutes) Individual/Family Therapy……..$85.00

Meetings……...……$125.00/hr
This includes all travel time, meeting participation, and meeting preparation. After the first hour, this is invoiced in 15-minute increments.

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

Court Fees……$350.00/hr
Court fees include all requested court appearances, travel to the courthouse, preparation, and documentation time. There is a 4-hour minimum for court appearances. Minimum must be paid at least 48 hours in advance of the court date.

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

Late/No Show Fees……...$100.00

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

Financial Policies

- I understand that all fees are to be paid, in full, at the time services are rendered unless alternative arrangements have been made with the therapist. All fees must be paid in full prior to scheduling a follow up session.

- 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.

- I understand ALL cancellations require a minimum of 24-hours advance notice. Insurance companies do not cover fees for late cancellations/no show appointments. Late cancellations (after the 24-hour period) and no show appointments are subject to a $100.00 fee and are the responsibility of the client/guardian.

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

- I authorize my credit card to be processed for charges related to services including copays, deductibles, full session payments, no show/late cancellation fees, and other services outlined in this agreement.

- I understand that in the event I choose to dispute a credit/debit card charge that services may be terminated if the charge was in compliance with this agreement.

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

- I understand that Heal Together Counseling has the right to terminate services if client balances are not paid in full within 30 days from the date services are rendered.

- I understand that Heal Together Counseling will provide billing services only for contracted insurance carriers. Client's utilizing out-of-network insurance benefits will be required to pay session fees to Heal Together Counseling at the time services are rendered. Heal Together Counseling cannot guarantee insurance payment and cannot be held liable for any denials of payment.

- Heal Together Counseling accepts the following forms of payment: credit, debit, FSA and HSA cards.

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 agree to the conditions as outlined above.

Financial Responsibility Agreement & Policies

By signing below, I acknowledge that 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 agree to the conditions as outlined above.

_____	_____
Client Name	Date of Birth
_____	_____
Parent/Guardian Name	Date
_____	_____
Client/Parent/Guardian Signature	Therapist Signature

Credit Card Authorization Form

I authorize Heal Together Counseling, LLC to charge my credit card for all services provided as outlined above. In addition, I authorize Heal Together Counseling, LLC to charge my credit card in the event of a late cancellation/missed appointment that did not comply with the 24-hour cancellation policy. I guarantee payment for all services rendered.

Name as it appears on the card: _____

Type of card: VISA Master Card Discover HSA Other:_____

Card Number: _____

Expiration Date: _____ Security Code: _____

Address associated with the card:

Address: _____

City: _____ State: _____ Zip Code:_____

Phone: _____

Signature of Cardholder: _____

Relationship to client: _____

Date: _____