Strength of Life Counseling Services

Patient Financial Policy

Patient's name: _____Date of Birth: _____

Payment:

The cost of counseling with a LMHC is $185.00 for the initial evaluation (60 minutes). Subsequent sessions are billed at $155.00. The cost of counseling with a LMHCA is $150 for the initial evaluation (60 minutes). Subsequent sessions are billed at $135.

Insurance companies will not allow 90-minute sessions except for when medically necessary. If you would prefer to meet with your therapist for 90 minutes, then you may pay $80.00 for the additional 30 minutes. Please note that you will be required to pay your co-pay for the first hour, as well as the additional $80.00.

You are required to present a valid insurance card and driver's license as needed throughout your care.

Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided. Any outstanding balances, co-payments and deductibles are due prior to your appointment. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full by you.

Medicare and Medicaid: We do not contract with or accept Medicare or Medicaid.

Methods of Payment:

Cash, Personal Checks, Debit and Credit Cards. We request that a credit card be kept on file for your convenience and ours. **There is a 4% service fee for all debit, credit, and HSA cards**. For returned checks we assess a $35.00 NSF charge.

If the balance is not paid according to our terms, the patient understands that our office reports to an outside collection agency. In the event that your account is turned over to a collection agency, **the patient agrees to pay all additional fees assessed in the collection of the debt. These fees include collection agency fees and attorney fees.**

Cancellation:

Twenty-four hour notice of cancellation is required. **In general, it is not possible to fill a time slot on short notice that your therapist has reserved for you. It is, therefore, the policy of this office to charge 100.00 for a missed appointment or short notice cancellation.**

I understand that I am ultimately responsible for all fees for services. I have read, understood and agree to the above financial policy for payments of professional fees.

Signature: _____ Date:_____