Fee and Policy Agreement

Fees for services paid by client alone ("self-pay"):

Therapy sessions for individuals are $140 for 50 minutes, with longer sessions available for additional charge. Couples/family therapy sessions are $160 for 50 minutes. Fees are due at time of service unless other arrangements are agreed upon. Payments can be made with cash, check, or credit card. If special arrangements have been made, you will receive a statement at the beginning of each month reflecting your unpaid balance. Payment for the agreed-upon amount is expected within ten days of receipt of the statement.

Delinquent accounts may be charged 1 ½ % interest per month (18% annually). If your account becomes seriously delinquent, we reserve the right to resort to the necessary collection procedures. If these procedures become necessary, you will be held accountable to pay all reasonable legal fees toward the collection of your debt. A $20.00 service charge will be assessed for returned checks due to insufficient funds.

Time spent on written reports will be charged at the hourly rates.

Policies governing self-paid services:

Services are by appointment only and normally scheduled for 50 minutes. As this time is reserved exclusively for you, it is necessary to charge for appointments that are not cancelled at least 24 hours in advance. In the event of an emergency, special consideration may be given regarding the cancellation policy.

If you are using insurance benefits but the provider is out-of-network with your health plan, you may be able to seek reimbursement through your insurance carrier after you have paid for the service. We do not file out-of-network insurance claims on behalf of our clients. We will, upon request, issue you a monthly statement which you may use to file for reimbursement from your insurance provider.

Policies governing services covered by insurance benefits | Financial Responsibility:

I acknowledge the payment and insurance information set forth below and agree to pay for services rendered to me and/or facilitate the payment for services rendered to me by the provider(s) affiliated with Big Spring Counseling ("Practice," as listed below).

1. Payment of Fees: I agree to pay for charges for services as described in this agreement. I understand that:
    - Payment for sessions with providers affiliated with Practice is payable online through debit or credit card or ACH transfer, unless otherwise established
    - Payment for sessions is due after each session unless otherwise agreed upon and Practice will charge my card or bank account for my responsibility. Receipts may be provided at the time of the charge or monthly
    - I will be charged for sessions that I do not keep, **unless I provide a minimum of 24 hours' notice** to the provider affiliated with the Practice
    - I understand that I cannot submit bills for cancellations to my insurance company or managed care plan
2. Insurance and Managed Care Plans:

Practice participates in a number of insurance and managed care plans. If Practice participates in my plan, I agree to pay all applicable deductibles, co-payments, co-insurances and any other form of cost-sharing. If my insurance benefits run out, Practice will inform me of the ending date, and I will then be responsible for all charges dating from the end of insurance coverage. If my insurance plan denies the visit despite Practice following necessary procedures, I understand I may be responsible to pay in full for the service.

3. Assignment of Insurance Fees; Release of confidentiality for authorization of benefits and for clinical care:

I agree to allow my insurance plan or managed care plan to pay Practice directly, instead of paying me. In the event that my plan pays me directly, I will promptly turn the payment over to Practice unless I have already paid the charges myself. I authorize Practice to provide my insurance plan or managed care plan any information reasonably required to obtain insurance benefits and authorization for services. I authorize Practice to obtain at any time during my treatment here, any and all relevant clinical information from clinicians and facilities that have treated me and to furnish relevant clinical information to providers who will continue to treat me. I will indicate in writing any exceptions to this.

Policies governing services covered by EAP (Employee Assistance Program) benefits:

I acknowledge the payment and EAP company information set forth below and agree to pay for services rendered to me and/or facilitate the payment for services rendered to me by the provider(s) affiliated with Big Spring Counseling ("Practice," as listed below).

1. Payment of Fees: I agree to pay for charges for services as described in this agreement. I understand that:
    - **Payment for sessions to providers affiliated with Practice is typically paid-in-full by the EAP company (e.g., Lyra) up to the contracted annual limit provided by the EAP benefit**
    - After the contracted EAP counseling benefit is exhausted for the year, payment for any further sessions is due at the time of each session, unless otherwise agreed upon, and Practice will charge my card or bank account for my responsibility.
    - Any eligible health insurance plan for which Practice is in-network may be utilized for payment following exhaustion or expiration of EAP benefits, according to the applicable health plan's coverage limits, and I understand I am responsible for any applicable cost-sharing
    - I will be charged for any sessions that I do not keep, **unless I provide a minimum of 24 hours' notice** to the provider affiliated with the Practice
    - I understand that I cannot submit bills for cancellations to my EAP
2. Employee Assistance Program Benefits:

If Practice participates in my Employee Assistance Program (EAP), I understand and acknowledge that EAP counseling benefits are limited and short-term in scope, and the EAP benefit will not cover more sessions than what are contractually provided by the EAP company and the employer. I understand that I am responsible for payment of any fees incurred if and when I utilize services beyond what is covered contractually by the EAP. I understand this will include payment for services on a self-pay basis or via my health insurance benefits. If Practice is out-of-network with my insurance benefits, I understand that payment will be provided by me at the time of service.

3. Assignment of EAP fees; release of confidentiality for authorization of benefits and for clinical care:

I agree to allow my EAP to pay Practice directly, instead of paying me. In the event that my plan pays me directly, I will promptly turn the payment over to Practice unless I have already paid the charges myself. I authorize Practice to provide my EAP with any information reasonably required to obtain EAP benefits and authorization for services. I authorize Practice to obtain at any time during my treatment here, any and all relevant clinical information from clinicians and facilities that have treated me and to furnish relevant clinical information to providers who will continue to treat me. I will indicate in writing any exceptions to this.

Big Spring Counseling does not provide emergency or 24-hour coverage. In the event of an emergency, call 911 or go to your nearest emergency room.

Phone calls made by Jonathan Gray or Big Spring Counseling may be blocked or appear as "Private Number" on caller I.D.

Agreements

Of the phone numbers you listed on the Client Information sheet, please indicate any numbers at which we may NOT leave messages: _____

I have read and agree to the above policies and fees. If I am not utilizing insurance benefits or an Employee Assistance Program (EAP) to pay for services, I agree to pay $140 per 50-minute session for individual therapy, and I understand that I am responsible for full payment of this amount.

_____
Print client (parent or guardian for minor) name

_____
Signature of Client (parent or guardian for minor)

_____
Date