EDINA COUNSELING CENTER

PAYMENT AGREEMENT

Unless I am a provider for your insurance company, payment is due in full on the day of service. If I am a provider for your insurance company you will be responsible for any co-payment on the day of service. If you are going to be paying and submitting to your insurance company on your own, I will provide you with a detailed receipt that should have all of the information your insurance company will require.

Balances left unpaid by you will be assessed a finance charge of 12% APR after 30 days. Unpaid bills may be sent to collections if, after several attempts, payment is not made.

Statements may be sent out by mail or email. Would you be willing to have your statements emailed to you? Y N

If so, which email address would you like to have statements sent to?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You may be contacted with appointment reminders. How would you like to be contacted? Email Phone call Text

A service charge of $20 will be charged for any checks returned due to insufficient funds. If bank charges exceed this amount, additional fees may be charged.

FEES

ONE HOUR PSYCHOTHERAPY $190.00

ONE HOUR DIAGNOSTIC ASSESSMENT/INTAKE $220.00

GROUP THERAPY $65.00

CONFIDENTIALITY AND ITS LIMITATIONS

All information you share is confidential and cannot be released without your written consent, except in the following cases:

* if you are going to hurt yourself or someone else
* if there is suspected abuse or neglect of children (including drug use during pregnancy)
* insurance companies need certain information to authorize and pay for sessions
* records can be subpoenaed

In unusual circumstances, you may become involved in litigation that may require my participation.  You will be expected to pay for the professional time required even if I am compelled to testify by another party.  Because of the complexity and difficulty of legal involvement, I charge twice my usual hourly fee for preparation for and attendance at any legal proceeding.

INSURANCE

I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits either to myself or to the party who accepts assignment.

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Patient or Authorized Person’s Signature Date

I authorize payment of medical benefits to this provider for services on claim forms.

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Patient or Authorized Person’s Signature Date

LATE CANCELS/FAILED APPOINTMENTS

Cancelled appointments require no less than 24 hour notice. Appointments failed or cancelled with less than 24 hour notice will be charged to you at the full hourly rate (PLEASE NOTE THAT INSURANCE COMPANIES DO NOT PAY ANY PART OF MISSED APPOINTMENTS). Because insurance companies do not pay for appointments you miss, you will completely responsible for the full fee. If you have agreed to join a group with a minimum 10 week commitment you will be responsible for payment of the 10 groups whether or not you complete your commitment.

Feel free to ask any questions you have about any of these items.

Signing this agreement means that you have read this information, have had it explained to you and that you understand and agree to the information in this payment agreement.

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CLIENT/GUARDIAN SIGNATURE DATE