SPECTRUM COUNSELING

Fee policy & Credit Card Authorization

OUT OF POCKET PAYMENTS

The fee of **$ 175.00 per session** is payable at the beginning of each session unless other arrangements have been made. **The intake session fee is $ 225.00.** You may use cash, check, or credit card.

INSURANCE PAYMENTS

Insurance coverage differs, so please check with your insurance company to determine your benefits for mental health coverage. Please be aware that the information your insurance company provides to you or Spectrum Counseling is not a guarantee of the benefits provided or paid by the insurance company.

My insurance carrier is ____

The main policy holder is ____________________________Date of birth______________

Co-pay $___________________Payable at each visit.

Fee <u>$225.00 Intake</u> 175.00 <u>50-60 minute sessions</u>

1. The fee of $ 175.00 per session is payable at the beginning of each session unless other arrangements have been made. The intake session fee is $ 225.00. You may use cash, check, or credit card.

2. The client is fully and directly responsible to Spectrum Counseling for the payment of services rendered. Insurance coverage differs, so please check with your insurance company to determine the requirements for mental health coverage.

3. Additional fees will be charged for psychological testing.

4. If payment becomes a problem, you are encouraged to discuss this directly with your therapist to consider other alternatives.

5. If fees change during the course of treatment, you will be given adequate notice of these changes.

6. You will be charged $75.00 for missed appointments or appointments canceled with less than a 24-hour notice (except in cases of illness, emergency or severe weather).

7. Fees for telephone contacts will be prorated, based on the standard hourly fee.

8. Overdue payments will be assessed a 5% monthly interest fee. Fees for telephone contact will be prorated based on the standard hourly fee.

10. I accept full responsibility for services provided by Spectrum Counseling.

CREDIT CARD AUTHORIZATION

_____Visa _____MasterCard _____American Express ______Discover _____HSA

Name of Cardholder____

Card #__________________________________Expiration Date_________Security code_____

- I understand that payments are due and charged at the beginning of each session.
- I understand that I will not be notified prior to my credit card being charge.
- I understand that my card will be stored in a way that is HIPAA compliant; either in a locked file, a password protected and encrypted computer, or an electronic health system.
- I will be charged for missed appointments or appointments cancelled with less than a 24 hour notice. INSURANCE WILL NOT PAY for missed or late cancelled

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- **I have read and understand Spectrum's Counseling agreement and fee policy.**
- **I understand that my signature authorizes Spectrum Counseling to charge my credit card in the manner described above.**
- **I have been advised of Spectrum Counseling's privacy policy and compliance with HIPAA.**
- **I understand the current fee schedule and my responsibility for payment of fees. I have been given a copy of the current fee policy and have been given the opportunity to discuss my financial situation with my therapist.**
- **I understand I will be responsible for all fees as indicated on the current fee schedule and as outlined on this payment contract.**
- **I am also aware that I may be charged a fee for a late cancel or no show appointment.**

Client Signature____Date____________