

Financial Agreement

1. Confidentiality: I provide a competent, confidential and safe environment in which individuals and families can work on their issues. I will not release confidential information without written consent of the client. Release of information forms can be provided. In the state of South Carolina there are circumstances in which disclosure may be directed by a court of law. Please ask if you have any questions.

2. The Fee varies:
 - Tricare Allowable Rate

 - BCBS Allowable Rate

 - My Normal Rate: The initial fee is \$150.00 to set up the file and for an hour session. Afterwards the fee per one-hour session is \$100.00 unless other arrangements are made.

 - Our Agreed Upon Fee: My fee will be \$_____ for the initial session and \$_____ for sessions thereafter.

 - Other Information about Fees:
 - i. If the fee is reduced below \$100.00 for self-pay and subsequently insurance pays, the fee will be readjusted to \$100.00 for all sessions covered by insurance.

 - ii. The agreed upon co-pay is expected to be paid following each session if insurance is being used; full payment is expected at each session if the deductible has not been reached or for self-pay clients.

 - iii. Phone calls other than to schedule or reschedule appointments will be billed at \$25.00 per 15 minutes.

 - iv. Cancellation of a session between 12 and 24 hours half fee is charged. Cancellation with 11 hours or less the full fee is charged except in emergency situations, unless you are sick, or unless the appointment can be filled from the waiting list.

3. Insurance Claims: I will file insurance claims **or** will provide you with receipts to submit your own claims. You should pre-authorize with your insurance company, provide me with an insurance claim form with your portion completed. However, it is your responsibility to keep the account current. I look for payment from you, not your insurance company.

4. 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 in claim forms.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES. I ACKNOWLEDGE RESPONSIBILITY FOR ALL FEES INCURRED AND AGREE TO ABIDE BY THESE POLICIES.

Signature of Client(s) Parent/guardian if under age 18 years

Signature of Counselor