Lake City Counseling, LLC Financial Responsibility Agreement

Client Name_____

Clinic Full Fees for Services

Initial Session with Masters Level Therapist……	$225.00	Late cancellation (within 24 hours)……	$ 50.00-$75.00
55-60-minute hour with Masters Level Therapist.....	$185.00	Non-sufficient funds check……	$ 35.00
60-minutes per hour in group treatment ……	$ 60.00	No Show fee..…… .	$ 50.00-$ 160.00

□ Self Pay Agreement

Fees will be established based on my income and family size. I agree that this fee will be paid at the time of each appointment.

I agree to inform Lake City Counseling of any change in income, employment, address, or telephone number.

I will be responsible for $_____ per counseling hour. Lake City Counseling will subsidize $_____ per counseling hour to equal the full fee of $185.00. I am responsible for $_____ for the intake (initial) session. I am responsible for $_____ per group session.

□ Insurance Agreement

If I have an insurance deductible to meet, I will pay full fee at the time of service until my deductible is met. Thereafter, any insurance **co-pay amount is due at the time of service.** Some programs require clients to pay as they go regardless of insurance.

I understand that I am responsible for providing all necessary requested insurance information to Lake City Counseling and my insurance company. If I fail to supply this information, or if I choose to not have these services submitted to my insurance company, I will be responsible for all applicable fees and will not be subsidized for services received.

If enrolled in an HMO, a referral for psychotherapy to Lake City Counseling must be provided before the start of therapy. If enrolled in private insurance, the agency's insurance information form will be completed and a release form signed.

I assign and authorize direct payment of all benefits due for client services to Lake City Counseling Services, LLC. A copy of this assignment may be used in lieu of the original. Lake City Counseling may release such information as may be necessary and pertinent to the insurance companies named in those documents to secure payment for services.

If I do not authorize Lake City Counseling to bill my insurance company, I will be responsible for the full cost of services.

Financial Responsibility

I accept financial responsibility for the charges incurred by myself and/or family members receiving psychotherapy services at Lake City Counseling Services, LLC. I agree to the financial terms as outlined above. I agree that, if I fail to keep a scheduled appointment, miss a group session, or do not give a 24-hour notice on an individual session, I will be responsible for any no-show, missed group, or late cancel charges as applicable, which I will pay prior to my next appointment. I understand and agree I am responsible for 1.5% interest per month on all outstanding balances 30 days past due unless payment arrangements are made. Account balances 60 days past due will be sent to collections if payment arrangements are not made.

_____ _____

Client's Signature Date Parent/Legal Guardian's Signature (if client is a minor) Date

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Clinic Representative Date