REFLECTIVE
COUNSELING

Ryan Logue, LCPC
Ryan@reflectivecounseling.net
www.ReflectiveCounseling.net

THERAPY FINANCIAL AGREEMENT

By signing below, you are accepting the terms and services and office policy as follows:

You understand that fees for services are billed at the following rates:

- Initial Visit: $225
- 45 – 50 minute Therapy Session: $200
- 30 – 45 minute Therapy Session: $175
- 15 – 30 minute "Check-In" Session: $150
- 45 – 50 minute Family Therapy Session: $225

If you are in crisis, do not wait for your therapist to return your call. Please go to your nearest emergency room or call 911. This practice does not provide crisis intervention or on-call services at this time.

_____ (Initial)

If you need to discuss an issue over the telephone between sessions that is going to take more than 10 minutes, we ask that you schedule an appointment so that you can be given the attention and time that you deserve. Phone calls should be reserved for scheduling and billing issues. Should the call involve a non-scheduling or billing issue or if the conversation exceeds 10 minutes a $50 fee will be incurred. An additional $50 will be billed for each additional 10 minutes following (first 10 minutes: no charge; second 10 minutes: $50 charge; third 10 minutes: a total of $100 charge, etc.).

_____ (Initial)

Additional services, such as telephone consultations, letters, additional reports, and other fees will be billed at a pro-rate of time based on $50 per hour.

_____ (Initial)

All missed appointments, or appointments not cancelled within 24 hours, will be billed the 'no-show' fee of $100. Missed or cancelled appointments are <u>not</u> billable to your insurance company, and will be charged directly to you.

_____ (Initial)

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Payment by personal checks will not be accepted. All payments will be made through credit card or electronic payment.

_____ (Initial)

Ryan Logue, LCPC, DBT-C, C-PD, CTMH is contracted with Blue Cross Blue Shield.

We do not have contractual relationships with any other insurance company at this time. If you have a different insurance provider, we will produce the necessary documentation for you to submit to your insurance carrier in order to receive out of network benefits. This does not waive your responsibility for fees incurred. Please consult with your insurance carrier to determine what services will be covered under your particular plan. By initialing below, you agree to indemnify our office from any error or omission in the preparation or filing of your insurance claim. It is your responsibility to make sure that insurance claims have been filed and are complete. If you would like us to file a claim on your behalf, please complete the patient information form completely and do not use nicknames.

_____ (Initial)

All pre-certification of services and continued certification of services for non-contracted insurances are your responsibility. You agree to pay for any services denied due to lack of pre-certification or required notification to your insurance plan.

_____ (Initial)

Unless otherwise agreed to in writing, you understand that payment is due by the date the service is provided. A $15 late fee will be applied for each week the fee is overdue. Services will cease after two consecutive non-payments. You will be discharged from the clinician's care after 90 days of non-payment and/or non-contact.

_____ (Initial)

If this account is referred to any agency or attorney for collection proceedings, you agree to pay costs incurred in the collection of this account, including but not limited to attorney's fees in the amount of 50% of your account balance at the time that account is placed.

_____ (Initial)

Signature of Guarantor/ Financially-Responsible Party: _____

Printed Name: _____ Date: _____

Client Signature: _____