Change Counseling LLC

Financial Agreement & Schedule of Fees

EFFECTIVE July 19, 2019

Client Name:_____ DOB:_____

Payment will be made in full at the time of service. By signing this form, I understand that I am agreeing to assume full responsibility to pay for services provided to the client identified above by Change Counseling.

I understand that Change Counseling will bill my insurance for services provided. I am responsible for any charges not covered by my insurance company. I agree to provide Change Counseling, LLC with a credit card number to be kept on file.

Payment may be made in the form of cash, personal check, or Credit Card. If I submit a check that is returned for insufficient funds, I understand and agree that I will be charged a $20.00 fee for the returned check, in addition to being responsible for the original balance due and any bank fees associated with the returned check.

I understand that accounts not paid at the time of service will be charged a $15 late fee per unpaid session in addition to the original balanced owed. I understand that Change Counseling, LLC will charge my credit card on file for any unpaid charges. I understand that Change Counseling may be forced to terminate services if fees are not paid according to the Financial Agreement.

I understand that I will be held financially responsible for the costs of treatment if I am the client identified above, the parent or legal guardian of the client identified above, or another party signing this form as a guarantor for the client identified above. I also understand and acknowledge that if I believe someone else to be responsible for paying these costs of treatment, it is my responsibility to pursue reimbursement from this individual, and I am otherwise responsible for fees of service.

Schedule of Fees:

Intake/Initial Evaluation	$150
Individual Counseling	$100
Family or Couples Counseling	$100
Minimal phone consultation or correspondence (under 15 minutes)	No charge

Change Counseling LLC

No-call/No-show to appointment, or
cancellation less than 24 hours in advance $25 fee

I have read, understand, and agree to the schedule of fees.

Responsible Party Name *(print)*:_____ Relationship:_____

Responsible Party Signature:_____ Date:_____

Witness Name *(print)*:_____ Date:_____

Witness Signature:_____

Please note that these fees are standard for those without insurance or pursuing self-pay options. For clients with insurance, your insurance company and Change Counseling, LLC have a separate agreed rate based on your insurance coverage. Please discuss with your therapist prior to engaging in services if you have any concerns your ability to pay.

All fees are due at the time of service.

A 24-hour notice of cancellation is required; the fee above will be charged if you do not alert your therapist of a cancellation, or attend your scheduled appointment.

We accept payment via Cash, Check or Credit Cards

**Please see front side of form for complete terms of financial agreement.

Thank you!