Cultivating Hope Counseling Services, PLLC
Payment Contract

Name(s): _____ Number: _____
Address: _____ City: _____ State: _____ Zip: _____

FEES FOR PROFESSIONAL SERVICES

I (we) agree to pay the clinic:
A fee of $130.00 per session (defined as 50 minutes for assessment, testing, and individual counseling).
A fee of $180.00 per session (defined as 50 minutes for assessment, testing and couples OR family counseling).
A fee of $75.00 is charged for missed appointments or cancellations with less than 24 hours' notice.
Fees for any other services not listed here or covered by insurance will be determined by CHCS.

CLIENTS WITH INSURANCE (DEDUCTIBLE AND CO-PAYMENT AGREEMENT)

Payment rates are pre-determined by insurance companies as well as third-party payers. Your policy, if any, is a contract between you and the insurance company, as a service to you Cultivating Hope Counseling Services, PLLC will bill insurance companies and other third-party payers. The person responsible for payment of treatment is responsible to pay for services regardless of any insurance company's arbitrary determination of usual and customary rates. Your insurance company may not pay for services that they consider to be no efficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance of the rates listed above.

Estimated Insurance Benefits

Insurance Company or Third-Party Payer_____

1. $ _____ Deductible amount (paid by insured party)
2. Co-payment _____ % ($ _____/clinical unit) for first _____ visits.
3. Co-payment _____ % ($ _____ /clinical unit) up to _____ visits.
4. The policy limit is _____ per year: _____ annual _____ calendar

It is suggested you confirm these provisions with the insurance company. The person responsible for payment of account shall make payment for services that are not paid by your insurance policy, all co-payments, and deductibles.

RELEASE OF INFORMATION AUTHORIZATION TO THIRD PARTY

I (we) authorize Cultivating Hope Counseling Services, PLLC to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above-listed third-party payer or insurance company for the purpose of receiving payment directly to _____.

I (we) understand that access to this information will be limited to determining insurance benefits and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who

will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____ Date: _____/_____/_____

Person(s) receiving services: _____ Date: _____/_____/_____

Person(s) or guardian(s): _____ Date: _____/_____/_____

CREDIT CARD & PRE-AUTHORIZED CHARGE

I authorize Cultivating Hope Counseling Services to keep my signature on file and charge my card listed below for session fees (including missed appointments or cancellations less than 24 hours prior to the appointment), and any balances of fees not paid within 60 days.

I understand that this form is valid for one year unless I cancel the authorization through written notice to Cultivating Hope Counseling Services, PLLC.

Customer's Name: _____

Cardholder's Name: _____

Cardholder's Signature: _____

Card Type: _____Visa _____MasterCard _____Discover _____American Express
Account Number: _____
Card Verification Number: _____
Billing zip code: _____
Expiration Date: _____

ALL CLIENTS

Payments, co-payments, and deductible amounts are due at the time of service.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____

Date: _____/_____/_____