



Financial Policies and Fee Agreement

Welcome, and thank you for choosing me to provide counseling services. This document will tell you about my fees and financial policies.

- **Fees:** My standard fee is \$125.00 per 50-minute session for individual, couples, or family counseling. For those without insurance or other third-party coverage who also meet income guidelines, I offer a discounted fee schedule according to household income and dependents from \$67.50 per 50-minute session. I reserve the right to raise my fees with 60 days advance notice.
- **Additional Services:** Fees may be charged on a prorated basis for other professional activities necessary for good clinical care, or for professional services you may need or request from me. Please note that insurance generally does not cover these charges. I will notify you before charging you fees for any of these services, which may include but are not limited to: time spent writing letters, reports, or treatment summaries beyond standard charting; telephone conversations initiated by you and lasting over 10 minutes; my attendance at meetings requested or authorized by you; consultations with others on your behalf; time to prepare, travel to and from, and attend any legal proceedings regarding my work with you.
- **Insurance:** I am happy to file claims with your insurance company. While I may check with your insurance company to verify benefits for my billing purposes, it is your responsibility to know whether your insurance plan covers my services and to find out your out-of-pocket costs prior to starting work with me. If insurance does not pay as expected, you are responsible for paying the remaining amount due. It is your responsibility to notify me of any changes in your insurance prior to the first session held after the change is in effect. Please note that policy benefits may change from year to year, and it is your responsibility to know how those changes may impact your out-of-pocket costs.
- **Payments:** The fee for each session is due at the beginning of each session unless the session is expected to be covered by insurance, in which case any co-pay, estimated coinsurance, and/or deductible for the session is due at the beginning of the session. If payment is not made at the time of the session, it must be sent by mail before the next session. Cash, money orders, or personal checks are accepted.
- **Late Payments:** If payment due has not been made by the following session, additional sessions will not be scheduled until payment is received or a payment plan is made and agreed to in writing.
- **Statements:** Upon request, I will provide you with receipts and/or statements for your records.
- **Billing:** Any remaining amounts due after insurance payment/claim processing are due 30 days from the date billed.
- **Finance Charges:** in the event that your account becomes past due and finance charges are assessed, the rate will be 1.5% per month with a \$5.00 minimum late fee per month.
- **Out-of-Network Insurance Plans:** If I am not on the preferred provider panel for your insurance plan, and if your insurance plan does not make payments directly to me, the full fee for the session is due at the

time of session. If you are unsure whether I am a preferred provider for your plan, please check with your insurance company.

- **Late Appearance:** If I am late starting our session, the full 50-minute session will be available to you. If this happens and you need to leave prior to the end of 50 minutes, the session fee will be pro-rated. If you are late appearing for our session, we will meet only until the scheduled end of the session, but payment for the full session will be due. Please note that insurance plans generally do not pay for time you are not here, so you will be responsible for the portion of the session that cannot be charged to insurance.
- **Cancellation Fees:** Sessions cancelled with less than 24 hours notice will be charged at 50% of the session fee, and this will be due at the start of your next session. Exceptions to this fee may be made in cases of emergency or sudden illness. You are responsible for arranging time away from work for your appointments; the fee will not be waived for cancellations due to work attendance requirements. **All cancellations must be made by phone prior to the scheduled start time of the cancelled session.** Please note that insurance plans do not generally pay for cancelled sessions.
- **Missed Appointments:** Scheduled sessions not cancelled and not attended by you will be charged at 100% of the session fee, and this will be due at the start of your next session. Exceptions to this fee may be made in cases of emergency. Please note that insurance plans do not generally pay for missed appointments.
- **Returned Checks:** there is a \$25 fee for any check returned for non-payment.

If you have any questions or concerns about the information contained in this disclosure statement, please ask me. Once you are certain you understand this entire document, please sign and date both copies of this form, keeping one copy for your records; the other copy will be a part of your records maintained at this office. Again, thank you for choosing me as a provider, and I look forward to working with you.

I agree to take financial responsibility for my scheduled sessions at the rate of \$125.00 per 50-minute session. (Initial the following if applicable)

_____ I understand that Dina Yerex, LPC, is not a preferred provider for my insurance plan and I may pay higher out-of-pocket costs in the form of co-pays, coinsurance, and/or deductibles, or that my insurance plan may not pay for out-of-network services.

_____ I understand that my insurance plan does not pay Dina Yerex, LPC, directly, and agree to pay the entire session fee at the time of service. Dina Yerex, LPC, will bill my insurance company and any payment will be sent directly to me.

I have read, and had explained to me where necessary, fully understand, agree with, and consent to the provisions of this Financial Policies and Fee Agreement.

Client's Signature

Printed Name

Date