Child and Family Counseling Center Financial Agreement

PATIENT NAME:
RESPONSIBLE PARTY:
THERAPIST:

PAYMENT ARRANGEMENTS: Payment is expected at the time of your service unless otherwise arranged. You are responsible for paying all copayments and any deductible that may be due, as well as notifying usabout any coordination of benefits

CANCELLATION/MISSED APPOINTMENT POLICY: **Please give 24 hours notice or you may be charged for the appointment**. Insurance companies do NOT reimburse for missed appointments. **We charge $80 for missed appointments**, though a higher fee may be charged for repeatedly missing appointments.

OTHER FEES: The following fee schedule will be used for services required which are NOT reimbursable by your insurance company. They are necessary to cover overhead costs. Ask your therapist if you have questions regarding these fees.

Telephone consultation: **$20 per 10 minutes**
This covers phone calls to/from attorneys, teachers, hospital staff, after hours calls, etc. No charge for EMERGENCY calls, though you may be charged for frequent emergency calls.

Court appearances: **Full hourly rate**
This applies to cases in which a therapist is requested or subpoenaed to appear on behalf of you or your child. You are also responsible if any party other than yourself issues a subpoena for the therapist to appear. Travel time, waiting time, and preparation time are included. A deposit may also be required.

Attorney's fees
You will be responsible for any attorney's fees that your therapist incurs as a result of assisting you or your child, including filing motions, representation in court, sending letters, etc.

Report preparation: **$10-50**
This includes letters for schools, doctors, attorneys, probation officers, etc. Fees vary depending on the amount of time required.

Record copying
If you request copies of your records, or if another agency requests copies of your records, the charge is $.50 per page for first 50 pages, $.25 per page thereafter, plus postage. This fee is stipulated by Virginia regulations.

I hereby authorize Child and Family Counseling Center to release necessary information concerning my treatment to my insurance carrier, in accordance with the Code of Virginia. I hereby acknowledge responsibility for this account and guarantee payment of all charges against this account, including collections costs. I understand that this account is my responsibility and not that of my insurance company.

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Signature of Responsible Party **Date**

_____ _____

Signature of Witness **Date**