FEE CONTRACT

**The following policies are provided for our mutual understanding and agreement. These policies protect both the client and therapist from any misunderstanding and/or false expectations. If you have questions or concerns about these policies, please discuss them with me before signing the contract.*

- I am committed to providing the best treatment for my clients at a rate that takes into account the current economic climate. As a result, the cost for therapy sessions is $105 per 50-minute session or $125 per 60-minute session. *(If you are utilizing insurance to pay for your sessions, the session cost is equaled to your co-payment unless you are still paying your deductible.)*

  ☐ # EAP sessions_____ Initials: _____

  ☐ Session Cost: $_____ Initials: _____**** to be verified with insurance

  ****I understand that my benefits will be verified with insurance and agree to pay any balance. _____

- I accept cash, check, and all major credit cards (Visa, MasterCard, Discover, American Express) as methods of payment.

- Payment is due at the time of each appointment. Please have your cash or pre-written check ready prior to the beginning of each session. If you pay by cash or check, a receipt can be provided upon request. You and I will receive email confirmation of your payment and the amount paid.

- **REGARDING MISSED APPOINTMENTS**: *In order to avoid charges for missed appointments, appointments must be canceled at least 24 hours in advance*. If you do not cancel within 24 hours, you will be charged the full fee for the missed therapy appointment. In addition, if you do not show for a scheduled appointment or do not cancel a scheduled appointment with AT LEAST 24-hour notice, all treatment services will be terminated and any future appointments will be made only when the missed appointment is paid for. However, if you no-show repeatedly, your treatment will be terminated. Please note: Insurance will not pay for missed sessions. Therefore, payment is equal to the cost of a session, which is $100/50 minutes and $120/one hour and will be your responsibility. By initialing, I am agreeing to this policy regarding missed appointments. _____

- If you are 15 minutes or more minutes late to three appointments in a 2-month time period, therapy will be terminated and you will not be eligible to return to my practice. By initialing, I am agreeing to this policy regarding being late. _____

- In addition to therapy sessions, please be aware that you will be charged a fee prorated at the hourly rate for work conducted between sessions. This includes, but is not limited to: phone conversations which exceed 15 minutes in length, filling out forms generated on your behalf, and creating and sending documentation also generated on your behalf such as letters or treatment summaries. You will also be charged $0.15 cents per page when copying records for release to another provider.

- Due to the complexity and difficulty of legal involvement, court involvement (including preparation, portal-to-portal time, and court attendance) is billed at a separate rate of $300.00 per hour.

- At this time, I accept the following insurances: ***Anthem Blue Cross/Blue Shield, and Cigna***. For these insurance carriers, you are required to pay your co-payment at the time of service. If you wish to use insurance not accepted by my practice to cover the cost of therapy, it is your responsibility to submit the necessary paperwork directly to the insurance company for reimbursement. I am happy to provide documentation of payment and services rendered as needed. In addition, I will also provide the same documentation for any flex spending or HSA account as needed. IMPORTANT: If you are insured, but the insurance company denies the claim, you are responsible for the entire payment. In addition, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

- If circumstances arise during treatment that make it difficult for you to meet your payment obligations, please feel free to discuss available options with me. Be advised that failure to meet your payment obligations may result in termination of treatment services. In addition, account information may be submitted to a collection agency for any balances over 90 days past due. Any additional expenses incurred in the collection process will be your responsibility.

By signing below, I am indicating that I have read, understood, and agree to abide by the terms and conditions set forth in this contract.

_____ _____

Person responsible for payment (Client or Parent/Guardian (if applicable)) Erin M. Wick, MA, LPC, CACIII

_____ _____

Date Date

******Verbally reviewed in intake session by Erin Wick with client on _____. _____

Current Date Initials