

Psychotherapy Office
Of
Aracely Neeley, LCSW
FEE SCHEDULE AND POLICY ON PAYMENT OF FEES

The undersigned understands and agrees to accept full financial responsibility for all charges and to pay the portion not expected to be covered by insurance. If remittance from the insurance company is not received, the therapist reserves the right to collect payment from the client and or client's guarantor. Should the account be referred to an attorney or collection agency, the undersigned client or client's guarantor may be responsible for actual attorney's fees and or collection expenses.

The fee for your initial session is \$ _____. The fee for each session thereafter is \$ _____. Your co-pay is \$ _____. Additional time may be charged accordingly.

PLEASE NOTE: Phone consultations lasting in excess of 10 minutes may be charged accordingly.

You have _____ EAP (EMPLOYEE ASSISTANCE PROGRAM) sessions available to you at no charge. Further sessions may be available through your medical benefits with differing co-pays and fees. This is a benefit provided to you by your employer. It is the responsibility of the client to inquire about these benefits and to provide verification of such benefits at the first appointment.

PLEASE NOTE:

CANCELLATION OF THERAPY APOINTMENTS MUST BE MADE AT LEAST 24 HOURS PRIOR TO THE SCHEDULED SESSION. IF A 24 HOUR (a minimum of one business day), NOTICE IS NOT GIVEN, THE SESSION WILL BE BILLED TO YOU, NOT YOUR INSURANCE COMPANY. THE SESSION FEE FOR A CANCELLATION without a 24 hour notice OR MISSED SESSION IS \$98 and must be paid prior to any other scheduled appointments. Failure to pay forfeits any future appointments (for those clients who have standing appointments), until your account is considered current and paid in full.

I have read the fee schedule and policy on payment of fees.

Signature of Client

Signature of Therapist

Date

Date