Financial Responsibility

Client Name:________________________________

Fees for Services

Initial sessions:

With Masters Level Therapist	$ 187.50*	No show for scheduled appt	$ 25.00*
With Ph.D	$ 225.00*	Late cancellation (within 24hrs)	$ 25.00*
50-minute hour with Masters Level Therapist	$ 125.00*	Non-sufficient funds check	$ 25.00*
50-minute hour with Ph.D Psychologist	$ 150.00*	Psychiatrist	$262.50*
50-minute hour in group treatment	$ 52.50*	Psychiatrist 15-30 min Med. Eval	$175.00*

The following policies keep our billing costs and the cost of our service down. All inactive accounts are forwarded to our collection service.

If your insurance/MA benefits would terminate, or your maximum benefit for the year is used, your liability will be based on the self-pay portion on this agreement.

☐ Insurance Agreement

If I have an insurance deductible to meet, I will pay full fee at the time of service until my deductible is met. Thereafter, any insurance co-pay amount is due at the time of service*.

I understand that I am responsible for providing all necessary requested insurance information to Northland Counseling Services and to my insurance company. If I fail to supply this information, or if I choose to not have these services submitted to my insurance company, I will be responsible for all applicable fees.

If enrolled in an HMO, a referral for psychotherapy to Northland Counseling Services must be provided before the start of therapy. If enrolled in private insurance, the agency's insurance information form will be completed and a release form signed.

I assign and authorize direct payment of all benefits due for client services to Northland Counseling Services. A copy of this assignment may be used in lieu of the original. Northland Counseling Services may release such information as may be necessary and pertinent to the insurance companies named in those documents to secure payment for services.

If I do not authorize to Northland Counseling Services to bill my insurance company, I will be responsible for the full cost of services.

**** Some programs may not be covered by insurance.***

☐ Medical Assistance Agreement

My MA co-payment per counseling hour for individual will be $____________ ($____________) for minors.
My MA co-payment per counseling hour for group will be $________________________.

In order to bill MA, I agree to provide the following information:

1. My MA card must be shown at the time of each visit or upon request of staff.
2. A signed and dated doctor's referral must be provided at the beginning of therapy and a prescription for therapy must be provided annually thereafter.

☐ Self-Pay Agreement

I understand that my counseling fee will be established based on my income and family size. I agree that this fee will be paid at the time of each appointment. Charges for an appointment with the Psychiatrist are based on the full fee. I agree to inform Northland Counseling Services of any change in income, employment, address, or telephone number.
I will be responsible for $__________________ per counseling hour.
I am responsible for $_____________________ for the intake session.

☐ Financial Responsibility

I accept financial responsibility for the charges incurred by myself and/or family members receiving psychotherapy services at Northland Counseling Services. I agree to the financial terms as outlined above. I agree that if I fail to keep a scheduled appointment or do not give a 24-hour notice, I will be responsible for my co-payment fee charge and/or any no-show charges as applicable, which I will pay prior to my next appointment.

SIGN X HERE

Client's Signature **Date** **Parent/ Guardian's Signature (if client is a minor)** **Date**

Agency Representative **Date**