**FINANCIAL POLICY**

Welcome to my practice and thank you for choosing to work with me.

Following is information about my financial policies. Please review it carefully and discuss with me any questions that you may have.

**Scheduling and Cancellations**

All sessions must be scheduled in advance. Frequency of appointment is determined by client’s need and treatment plan. Scheduling an appointment is my commitment to reserve time for you. **Cancellation is required at least 24 hours in advance, or you will be charged a $120.00 fee for this time.**

**Inclement Weather and Emergencies**

In the event of inclement weather please call my office at 908-208-2119 and listen for posted message indicating whether the office will be open. If the office is open but you do not feel safe driving, you will have an option to switch to virtual/telehealth session. If unique circumstances do not allow you to have adequate privacy for the telehealth session, please call me as soon as you make that decision. Cancellation fee will not be assessed in this event. Similarly, cancellation fee will not be charged in the event that you have a serious emergency or illness. However, please inform me of the situation as soon as possible.

**Rates and Payment**

$175 per 75 minute/ initial intake assessment

$150 per 42- 53 minute/ individual session

$180 per 42 -54 minute/ family session/couple

You are expected to pay for services at the start of each appointment. Paying at the onset of the session allows us to use all of your session time to address your needs. Acceptable forms of payment are cash, credit cards or checks made out to “*Touchstone Counseling Services, LLC.”* A $35 fee will be charged for retuned checks.

**Possible Additional Fees**

Additional out of pocket fees may be incurred from time to time. These fees are NOT reimbursable by health insurance companies.

* Out of office service (i.e. classroom observations, IEP meetings or collaborative meetings with other mental health professionals for case coordination) [includes travel time]
* $200 per individual session
* $230 per family session
* $250 per intake assessment (75 minutes)
* $250 per session hour IEP meeting/meeting with another care provider/professional
* Letters/Reports/Case Summaries
* From time to time you may need me to write a letter or repot to certain professional or organizations involve in your care. My fee for preparation of these reports is $35 per 15 minutes and will be delivered upon your payment in full.
* Photocopies
* $1.00 per page – not to exceed $100 (copies of records, session notes, etc...)
* Legal/Court Proceedings
* Advance retainer covering a minimum of 4 billable hours at the rate of $300 per hour. Billable time includes preparing for/attending litigation, including but not limited to preparing testimony, conferences in person or by telephone with any attorneys, travel time, waiting time, testimony and/or deposition time ((regardless of which side calls me).

**Health Insurance /Out-of –Network Benefits** **Only**

This means that I am not contracted with your insurance carrier to provide services to you. However, you may be able to select an out of network provider and your insurer may reimburse you at their usual and customary percentage rate. You will need to contact your insurance carrier and find out about your **out- of- network benefits** for behavioral health/mental health services. If mental health benefits are available be sure to ask if your deductible is met, what is the maximum number of sessions covered and if pre-authorization is required. I do not submit claims for out-of- network insurance coverage. However, I will provide you with a monthly statement that will have all the necessary information for you to complete and submit your insurance claim (please let me know if you need a statement more frequently).

**Health Insurance /In-Network**

This means that I am a credentialed provider with your health insurance company and have agreed to a negotiated reimbursement rate. Claims for services rendered to you will be submitted by the clinician to your health insurance company directly. Even though I am in-network provider with your health insurance company you will be financially responsible for your co-pays, deductibles, co-insurance as well as any denied claims.

**Missed Payments**

If you are unable to pay your fees as mutually agreed upon, please discuss the matter with me immediately and prior to the session. Treatment may be temporarily suspended if fees for more than 2 sessions are owed.

I have read, understood and agreed to the above financial policies

Client Name: Client Signature: Date:

Client Name: Client Signature: Date:

Parent/Guardian: Parent/Guardian Signature: Date:

Parent/Guardian: Parent/Guardian Signature: Date:

My signature below indicates that I have discussed this form with you and have answered all questions you have regarding this information

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Therapist’s Signature Date