**FINCANCIAL POLICY**

**Fees.** Counseling sessions are 50 minutes long. The fee for a 50 minute session, either face-to-face or by phone, is $140. The fee for the first session (assessment) is $170 and will last 90 minutes. A first time patient is charged $35 by credit card to hold their appointment time. This fee is non-refundable but it is deducted from your first visit. Payment is collected at the first of the session. **I also understand that should I, or my attorney or others acting in my behalf, for any reason subpoena RMT and/or records, there is a fee of $250 per hour if attendance at court or any associated hearing is required.** Credit card payments will require a 3% tax.

**Therapeutic Forms.** There is a $35.00 fee for the completion of any therapeutic information such as letters, legal papers, or disability forms. This fee is due before the forms are completed and cannot be billed toward your insurance.

**Charges.** Occasionally there extra charges or other altered charges but in your case the fee for the 50 minute will be _____.

**INSURANCE ASSIGNMENT**. ARCC insurance program is designed to keep your out-of-pocket expense to a minimum. As a courtesy to you, we will bill your health insurance carrier on your behalf and wait up to 90 days for payment. Please remember, however, that you are ultimately responsible for payment. On Day 60, if the bill has not been paid by your insurance company, you will be responsible for the amount. Any payments made on these claims thereafter will be immediately refunded to you. Initial _____

Co Payment $_____ Co Insurance $_____ Deductable $_____

**Self-Pay Client.** Clients without insurance or whose insurance does not cover the cost of mental health counseling because of high deductibles or other limitations are personally responsible for payment at the time the service is rendered. Initial _____

**Signature**

I have read or had explained to me all the above terms and conditions of therapy, and have signed below to indicate my agreement with each of these terms and conditions:

_____

Client Date

_____

Client (Adult family member, domestic partner, or other adult) Date

_____

Client (Adult family member, domestic partner, or other adult) Date

_____

Client (Adult family member, domestic partner, or other adult) Date

_____

Therapist Date

*ARCC will include a primary therapist on each case, and may or may not include a clinical supervisor, professional peer consultants, and clinical support staff.