Fee Contract

Client Name____ Client #_________________

STATEMENT OF CHARGES: It is important that you understand the behavioral health services covered by your insurance policy. You can obtain this information by contacting your insurance company directly. Some services such as report writing, attendance at meetings and court testimony are not covered by insurance. Charges per service are listed below.

90791		Diagnostic Intake/Assessment		$195.00
90832		Individual Psychotherapy Session (16-37 minutes)		$90.00
90834		Individual Psychotherapy Session (38-52 minutes)		$135.00
90837		Individual Psychotherapy Session (53-60 minutes)		$180.00
90839		Individual Psychotherapy with crisis (60 minutes)		$180.00
90840		Crisis code add-on for each additional 30 minutes		$75.00
90785		Play Therapy add-on code per session		$20.00
90846		Family Psychotherapy Session w/out client (53-60 min.)		$135.00
90847		Family Psychotherapy Session with client (53-60 minutes)		$135.00
90853		Group Psychotherapy Session (per session)		$45.00
		Court report		$125.00
		Deposition, court testimony per hour with 1 hour prepaid		$125.00
		Completion of paperwork (FMLA, SSA, etc.)		$25.00
		No show fee (failure to cancel a missed appointment)		$25.00

INSURANCE INFORMATION

Insurance Company: ____________________________ Policy #: ________________ Group #: ___________

Policy Holder: ________________________________ DOB: _____________ Social Security #: ___________

Employer: ___________________________________ Relationship to client: ____________________________

Contact information for policy holder (only if different from client):

Address: ____ Phone: ________________

By signing, you agree to each of the following conditions:

1. The client or guardian of the client is responsible for payment of fees for professional services provided by Michelle D. Scheu, LSCSW. Payment is due within 30 days of billing unless other arrangements are agreed upon in writing. Charges on statements are agreed to be correct unless you protest in writing within 30 days of the billing date. Charges unpaid after 30 days may be subject to collection. Services that have been terminated due to non-payment will not be re-opened until payment of the account is made in full.
2. If the client is covered by an insurance policy and I agree to bill that company for services rendered, you are responsible for completing any required preauthorization and coordination of benefits forms and for all applicable co-pays, deductibles, coinsurance, and non-allowable charges. If your insurance company denies payment for services rendered, I will notify you in writing and require payment of all sums due. In most cases, a mental health diagnosis must be provided to your insurance company for reimbursement. If your contract with an insurance company requires that I provide them with other information relevant to the services provided, I may be required to send copies of any records maintained here pertaining to your therapy sessions.
3. Co-pays are due at the time of service.
4. Medicaid clients may be liable for a client obligation under this program and will be required to pay this in full.
5. If the client or the service provided is not covered by insurance, Medicare or Medicaid, payment is due at the time of service. I accept cash, check and credit cards.
6. You agree to notify me of any changes in name, address, telephone number or insurance coverage.
7. A no show fee may be required prior to rescheduling if a missed appointment is not cancelled prior to the scheduled time.
8. Insufficient fund checks will be assessed a $30.00 charge.

ASSIGNMENT OF INSURANCE BENEFITS (To be completed for Insurance)

By signing this document, I agree to allow Michelle D. Scheu, LSCSW to release all information necessary for filing insurance claims and collecting fees from my insurance company. I hereby authorize payment for services rendered from my insurance company directly to Michelle D. Scheu, LSCSW, LLC. Benefits otherwise payable to me for treatment rendered by her will be paid to her upon receipt.

I have been given the opportunity to ask questions and agree with this fee contract.

I understand that I have the right to a copy of this document if I so desire.

_____ I have received a copy of this document.

_____ I have waived my right to receive a copy of this document.

____ ________________________
(Signature of Responsible Party) (Date)

____ ________________________
(Signature of Witness) (Date)

It is expressly understood that photocopies/fax of this form shall be as valid as the original.