Family Guidance Centers

Financial Procedures and Agreement

In order to help eliminate any misunderstandings with regards to your financial responsibilities, the following policies and procedures will be adhered to.

Psychological Services and Costs

Service	Fee Schedule
Initial Diagnostic Interview (90791)	$200
60 Minute Therapy Session (90837)	$175
45 Minute Therapy Session (90834)	$160
30 Minute Therapy Session (90832)	$120
Psychological Testing (per hour)	$175

These charges remain the same whether the treatment is on an individual, couple, or family basis. The psychological testing process and time required varies with the issues/problems to be evaluated, the type of testing instruments to be used and the time required by the psychologist to score and complete a report of the findings. For more information on psychological testing, please visit our website.

_____*(initial here)* **Financial Policies and Cost of Services**

Most insurance companies reimburse a portion of the cost of services. We will assist you as best we can to determine your copay, deductible, or coinsurance amounts and we will automatically file your claim, if accurate and current insurance information is provided. Each responsible party is required to complete the patient information form with accurate and complete information. Failure to provide current and accurate information may result in reimbursement denial by your insurance company. As a service to our clients, we will assist you in completing and filing the insurance claims. Further, a monthly statement will be sent to the address on file for accounts with balances above $5. Most insurance plans call for a deductible or co-payment then will typically pay a percentage of the costs thereafter. EACH CLIENT IS REQUIRED TO FULFILL THE DEDUCTIBLE AND THEN PAY THE REMAINING PERCENTAGE OR COPAY ON A SESSION BY SESSION BASIS. ANY OTHER ARRANGEMENTS MUST BE NEGOTIATED AT THE TIME TREATMENT HAS BEGUN, AND MUST BE IN WRITING. Otherwise, FGC will hold you responsible for professional services rendered. Please note, however, that you are responsible for verifying your insurance benefits, providing any required background or other information to the company prior to payment, and arranging for initial preauthorization of care, if required. Ultimately, you are responsible for your bill, not your insurance company.

_____ *(initial here)* **Records Release, Preparation of Letters or Reports, Non-Emergency Telephone Calls, and other Incidental Activities**

In recent years, healthcare companies have reduced reimbursement rates and limited coverage to face-to-face contact only. Records releases, reports, letters, disability certificates, telephone calls, and many other necessary activities are not covered by your insurance. Charges for these services are calculated based on the time required to complete the activity as shown in the fee schedule below.

_____ *(initial here)* **Court Related Activities**

Court and forensic activities are an additional out of pocket cost that is not covered by your insurance. As a general policy, our therapists cannot be available "on-call". **A required retainer of $1,500 is due at least 72 hours before the scheduled court appearance. Our fees are listed below.**The remainder of the costs will be billed after the court appearance and will be due upon receipt.

_____ *(initial here)* **Cancellation & No Show Policy**

A minimum of **24 hours notice is required for cancellation of appointments**. If this notice is not received or if the patient fails to show for the appointment, the Responsible Party will be charged $75 for the no show/late cancel appointment. No show or late cancel appointment fees are due immediately. Such charges will not be billed to the insurance company. Therapists may elect to terminate treatment for failure to attend scheduled appointments.

_____ *(initial here)* **Delinquent Accounts**

Every effort will be made to obtain reimbursement through your insurance plan if they are services covered by your insurance. However, it remains your full legal responsibility to assume the financial obligations for our bill should the insurance company deny any part of the claims for services rendered. Accounts are considered past due if no payments have been made for 30 days. Statement of charges sent to you are agreed to be correct and reasonable unless disputed in writing within 30 days. After a 90 day absence of payment, the account is delinquent and will be forwarded to collections. Should it be necessary to resort to a collection agency and/or attorney for the collection of your account, you agree to pay any attorney and collection fees not to exceed 1/3 of the unpaid balance and any court costs incurred in addition to the amount owed.

Services Not Covered by Insurance

Service	Fee Schedule
Preparation of **non-forensic** reports, letters, telephone or other conferences (including all patient or Responsible Party requested telephone contact), chart review, records releases per half hour*	$40
Court - preparatory time (including submission of records), phone calls, email or written letters, time away from office due to depositions or testimony Per Hour*	$220
Court - Depositions and Time Required Giving Testimony Per Hour*	$250
Court - Mileage	$0.58/mile
Court - Filing a document with the court	$100 Plus Court Fees
Court - Express Charge (If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $250 “express” charge	$250
Court - If the case is reset with notice of less than 72 business-hours, the client will be charged $500 (in addition to the retainer of $1,500)	$500
Court - A required retainer of $1,500 is due at least 72 hours before the scheduled court appearance. The remainder of the costs will be billed after the court appearance and will be due upon receipt.	$1,500 minimum
No Show or Late Cancellation Appointment Fee*	$75

(*These services are not covered by insurance)

I have read and agree to financial responsibilities for entering into counseling with FGC. Your signature below authorizes release of medical information necessary to file your insurance claim(s) and assign benefits to FGC. In the event that a legal collection action is necessary, you authorize FGC or its agent to make a credit investigation, including employment verification.

_____ _____ _____

Signature of Responsible Party Print Name Date