CW Counseling and Consulting, LLC
Payment Contract
Complete Top Portion Only

Patient Name: _____ Phone: _____
Address: _____

Person responsible for payment of account: _____ Phone: _____
Address: _____

Third-party (insurance, EAP) payer: _____ Phone: _____
Address: _____

Federal Truth in Lending Disclosure Statement for Professional Services

Part 1: Fees for Professional Services I agree to pay CW Counseling & Consulting, LLC a rate of $170.00 per clinical unit (defined as 90 minutes) for the initial session, $135.00 per clinical unit (defined as 60 minutes) and $120.00 per clinical unit (defined as 45 minutes) for individual. The fee of $125.00 for family and couples counseling per clinical unit (defined as 52-60 minutes). A $25.00 fee is charged for missed appointments. It is the patient's responsibility to pay the missed appointment fee. **Payments, co-pays, and deductibles are due at the time of service. Patients are asked to make payments and/or financial arrangements upon arrival/before session.** Patients who do not make responsible progress toward payment of retiring outstanding debt may, at the discretion of the provider be terminated from services. Patients terminated from services will be given 15 days' notice during which their emergency counseling needs will be addressed. Patients are still financially responsible for paying any services rendered during this time.

Part 2: Patients with Insurance (Deductible and Co-payment Agreement) Either you or your insurance company (listed above) have informed CW Counseling & Consulting, LLC that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated ins. benefits 1. $_____ Deductible Amount (paid by Patient)

2. Co-payment of $_____ for the first/last _____ visits.

3. Co-payment of $_____ for up to _____ visits.

4. The policy limit is _____ visits per year. _____ annual _____ calendar

Please confirm these provisions with your insurance company, as they are not guaranteed. The person responsible for payment shall make payment for services that are not paid by your insurance policy, all co-payments, any agreed upon services or testing or deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services they consider to not be effective, not medically or therapeutically necessary or ineligible (not covered by your policy or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part 1 above. If your insurance policy changes, or is discontinued, the patient assumes responsibility for full payment of services rendered.

I HEREBY CERTIFY that I have read and agree to the conditions, and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

_____

Signature of Person Responsible for Payment Date
Medicaid ID #

Updated 06/21