CW Counseling & Consulting, LLC

Dr. Carol Wright, Ed.D., LISW-CP-S
2400 Second Loop Road
Florence, South Carolina 29501
Phone: (843) 667-1905

PAYMENT CONTRACT & FINANCIAL RESPONSIBILITY AGREEMENT

Patient Information

Patient Name: ____
Date of Birth: _________________________

Fees for Services
I understand and agree to the following fee schedule:

- Initial Assessment (90 minutes): **$195.00**
- 60-Minute Session: **$175.00**
- 45–50 Minute Session: **$155.00**

Additional Services (Not Typically Covered by Insurance)

- Extensive Reports/Letters: $75.00
- Brief Reports/Letters: $45.00
- Court Appearance: $140.00/hour
- Consultation/Observation: $90.00/hour
- Phone Consultation: $40.00 per 15 minutes

Insurance and Financial Responsibility
I understand that:

- Insurance coverage is **not guaranteed**
- I am responsible for all **copays, deductibles, coinsurance, and non-covered services**
- I am responsible for all charges if insurance denies or does not pay for services
- Clinical information may be submitted to insurance companies as required

Crisis Services (CPT H2011) Financial Acknowledgment understand that crisis psychotherapy services may be provided when medically necessary and may be billed under **CPT Code H2011**

- Not all sessions qualify as crisis services
- Crisis sessions may be longer and billed differently than routine sessions
- I am responsible for any portion not covered by insurance

Initials Required: ________

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Missed Appointment Policy

A **minimum of 24-hour notice** is required to cancel or reschedule appointments.

- First three late cancellations/no-shows: $25 fee
- Fourth occurrence: Full session fee required

Missed appointment fees are **not covered by insurance**.

Initials Required: ________

Payment Terms

- Payment is due **at the time of service**, unless prior arrangements are made
- Accounts over 60 days may be subject to:
  - A **2% monthly late fee**
  - Collection agency or legal action

In the event of collections, only necessary information (name, services, balance) will be disclosed.

Returned Checks

A **$35 fee** will be charged for returned checks. Future payments may be required in cash or money order.

Agreement

By signing below, I acknowledge that:

- I have read and understand this financial agreement
- I accept full financial responsibility for services rendered
- I agree to comply with the policies outlined ab

Responsible Party Name (Print): ___________________________

Signature: ____ Date**:** __________

Relationship to Patient: __________________________________