

Denver Art Therapy & Counseling, LLC

INFORMED CONSENT AND FEE AGREEMENT FOR PSYCHOTHERAPY SERVICES FOR ADULTS

I, _____ agree to pay for psychotherapy services and other clinical services* for _____ according to the fee agreement between the therapist, Erin M. Brumleve, MA, LPC, ATR and the client.

The fee for psychotherapy, consultation, letter or report writing or other clinical services is \$ 90 per 55 minute session unless otherwise specified.

My co-pay is \$ _____. (N/A if Not Applicable.)

I understand the following terms apply to this agreement (Please initial):

____ I am responsible for understanding the details of my insurance coverage and attest that I have contacted my insurance company prior to beginning therapy. If my insurance company denies submitted claims due to an outstanding deductible, late precertification, or lack of outpatient mental health benefits, I am responsible for the entire psychotherapy balance.

____ It is policy to keep a credit card on file to be used for late cancellations or other types of services rendered. You may choose to use the card on file, or pre-pay for the session, or requested outside of session time (phone or email communication) using Pay Pal. Parties may keep two credit cards or two Pay Pal accounts for the purposes of separate billing.

____ Payment is expected prior to or at the time of service.

____ Accepted forms of payment include: cash, check, or credit card. There is a \$15 fee for all returned checks.

____ Clinical services are billed on a pro-rated basis after the first 15 minutes of each month. Phone calls and Emails for the purpose of *scheduling only* will not be charged.

____ * Other clinical services include, but are not limited to: emails, phone calls, letters, crisis intervention, consultation with auxiliary service providers, court related work, as well as preparation of clinical records and therapeutic documents.

____ I will inform the therapist immediately if there are changes in my ability or willingness to pay.

____ *I understand I will be charged \$45 for all cancellations with less than 24 hours notice.*

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____ *I understand I will be charged the full fee (\$90) for no-shows, or cancellations occurring less than 2 hours prior to my appointment.*

____ Services will be terminated if timely payment is not made as agreed to by this consent.

____ Consent to assume financial responsibility for these services does not entitle the third-party payer access to confidential information unless agreed in writing otherwise by the named above client.

____ *For Self Pay Clients Only:* upon my request I will be provided with a bill which is suitable for presenting to my insurance carrier for possible reimbursement. Not all conditions are reimbursable.

Client name (print)	Date	Signature
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Party Responsible for Payment Name (print)	Date	Signature
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Psychotherapist	Date	Signature
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