Denver Art Therapy & Counseling, LLC

INFORMED CONSENT AND FEE AGREEMENT FOR PSYCHOTHERAPY SERVICES FOR MINORS

A. Consent

We, ________________________________ and _______________________________, agree to pay for psychotherapy services and other clinical services* for ____.

B. Fees

1. The fees will be shared by the parties in the following manner:
   ________________________shall pay ____% and
   ________________________shall pay ____%.

2. 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.

3. The fee for psychotherapy, consultation, letter or report writing or other clinical services is $ 90 per 50-55 minute session unless otherwise specified. A portion of this fee may be covered by the insurance of one of the parties.

4. The co-pay is $_____. (N/A if not applicable.)

5. The parties understand the following terms apply to this agreement:

6. ***The parties are responsible for understanding the details of the insurance coverage. If the insurance company denies submitted claims due to an outstanding deductible or lack of outpatient mental health benefits, the parties responsible for the entire psychotherapy balance.***

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

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

9. Clinical services are billed on a pro-rated basis after the first 15 minutes of each month. Clinical services are billed in 1/10th of the hour increments. Phone calls and Emails for the purpose of *scheduling only* will not be charged.

10. 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.

11. If therapist is requested to testify or provide therapeutic documents to be utilized for court proceedings or is called to testify in court, the parties agree that she will compensated according to the following fee schedule for court related work, regardless of which party requests said action:

Court Testimony Preparation: $100/hour
Court Record Preparation: $100/hour
Mileage: $.75/mile
Copy of Record(s): $1.00/page
Counseling Report/Treatment Summary: $100/hour
Court Testimony: $125/hour – including time spent waiting to testify

C. Cancellation Policy: The parties understand that in the event that an appointment is cancelled or rescheduled, there is a 24-hour cancellation policy. The parties will be billed for the appointment if less that 24-hours notice is given. If one party does not appear for a scheduled joint session with the party and the client, or does not bring the client to that session, and has not given 24-hours notice, the party who does not appear or give proper notice will be responsible for both parties' portions of the fees.

1. With regard to joint sessions, if one party is more than 15 minutes late, the session is cancelled and the late party must pay for the entire session.

2. The parties understand the full fee ($90) is charged for no-shows.

D. Non-payment: Accounts not paid in a timely manner will be dealt with in the following manner. Accounts past due 60 days will be charged interest at the rate of 1.5% per month. Erin Brumleve, MA, LPC, ATR may seek the assistance of the court or a collection agency in collecting fees. Non-payment of fees may be grounds for the resignation. The parties will inform the therapist immediately if there are changes in their ability or willingness to pay.

We have carefully reviewed this Agreement and by our signatures below, we acknowledge and agree to all the terms:

This agreement shall remain valid until: ___________________________________

____
Parent/ Guardian of Client Signature   Date

____
Parent/ Guardian of Client Signature   Date

____
Party Responsible for Payment Signature   Date

____
Party Responsible for Payment Signature   Date

____

Therapist Signature Date