Client Name: _____

Richmond Creative Counseling, LLC

FINANCIAL AGREEMENT

In accordance with the services that will be provided by Richmond Creative Counseling, I hereby agree and authorize my insurance company to pay this agency in full for services rendered in accordance with my medical benefits as agreed to in my insurance policy. I hereby authorize Richmond Creative Counseling to release to my insurance company any information necessary for seeking reimbursement for the services listed below.

FEE SCHEDULE

Initial Therapy Evaluation (60 minutes)	$130
Initial Psychiatric Evaluation (60 minutes)	$300
Substance Abuse Assessment	$150
Therapy Session (45 to 60 minutes)	$110
Medication Management (up to 20 minutes)	$100
Group Therapy Session (60 to 90 minutes)	$ 45
Late Therapy Cancelation (less than 24 hours)	**$ 55/individual therapy; $22.50/group therapy (except Medicaid patients)**
Missed Therapy Appointment (no-show)	**$110/individual therapy; $45/group therapy (except Medicaid patients)**
Late Psychiatric Cancelation (less than 24 hours)	**$150/intake; $50/med mgmt. (except Medicaid patients)**
Missed Psychiatric Appointment (no-show)	**$300/intake; $100/med mgmt (except Medicaid patients)**
Court Appearance Retainer	$500
Court Appearance Fee/Depositions per hour (Therapist)	$300
Court Appearance Fee/Depositions per hour (Psych NP)	$400
Phone Consultation/Professional Fees per hour (Therapist)	$110/$300 (court related)
Phone Consultation/Professional Fees per hour (Psych NP)	$300/ $400 (court related)

CO-PAYMENTS

All applicable co-payments, deductibles, or any other out-of-pocket expenses are expected to be paid at the time of the appointment. The co-payment is your responsibility and payments are expected at the time of your appointment unless your insurance coverage requires another arrangement. Payment is accepted by cash, credit card, or check. Richmond Creative Counseling reserves the right to increase fees in the future to a reasonable amount and you will be given adequate advanced notice if this should occur.

My insurance company is _____.
The amount of my co-payment is $_____ as assigned by my insurance company.
Direct Rate is $_____.

MISSED APPOINTMENTS

I understand that it is my responsibility to schedule and ensure that these appointments are kept. I understand that if I am unable to attend my scheduled appointment that I must call, cancel and reschedule my appointment more than 24 hours before the appointment. I understand that I will be held responsible for any appointment that is not cancelled with 24 hours notice. I also understand that **my insurance company will not pay for missed appointments** and that I must pay the full fees for services rendered as stated in the above Fee Schedule. Medicaid patients are not charged for missed appointments.

INSURANCE PROCESSING

Your insurance company may require that you pre-authorize your treatment with us prior to your visit. It is your responsibility to monitor insurance benefits, deductibles, as well as effective and termination dates of coverage. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have any questions, please contact your plan administrator. Feel free to speak with your provider if assistance is needed with this.

By signing below, the undersigned affirms that he/she has read, understands and agrees to the finance agreement as outlined above. I authorize my insurance company to make payments directly to Richmond Creative Counseling for services rendered.

_____ _____
Individual/Guardian Signature Date