FEE AGREEMENT FOR PROFESSIONAL CLINICAL COUNSELOR SERVICES

FEES

Fees are based on the type of service provided and length of time:
Court and associated fees and non-psychotherapy professional service fees are $300 per hour.
Psychotherapy fees for intake $237 for 50-60 minutes
Psychotherapy follow-up counseling session $158 for 40-45 minutes

PAYMENT FOR COURT TESTIMONY:

If you choose to ignore the Ohio Revised Code which clearly defines the clinician's role and the clinician is required to testify for any reason in court pertaining to treatment, you will be responsible for paying the fee at $300 per hour for the amount of time spent in court, giving depositions, other court related business and travel time to and from the setting at the $300 per hour rate of your counselor's time. ***Insurance does not cover this expense.***

COURT FEE SCHEDULE:

- All fees charged for court activity are based on portal-to-portal travel.
- A retainer for the estimated full amount of the fee will be required one week before a court appearance.
- If actual fees exceed estimated fees, clients will be responsible for the remainder of the fee within one week of rendered services.
- Fees will be assessed base on Clinician's time spent preparing, traveling, and for lost revenue for 12 hour work days.

FEES FOR OTHER NON PSYCHOTHERAPY PROFESSIONAL SERVICE AND CANCELLATION POLICY:

PHONE CONSULTATIONS

Telephone consultations will be billed in 15 minute intervals based on the fee of $300 per hour. ***Insurance does not cover this cost.***

MEETINGS OUTSIDE THIS FACILITY

Any meetings that are requested outside of American Health Network, i.e. school, Job and Family Services, other therapist's offices and home visits will be charged at the $300 per hour fee which include preparation and travel to and from location. ***Insurance does not cover this cost.***

CORRESPONDENCE FEES

Correspondence to non-medical contacts and/or written reports which require considerable preparation that is not necessary for treatment (i.e. letters to attorneys, courts, parents, etc.) will be billed in 15 minute intervals based on $300 per hour. ***This will be your responsibility since insurance will not pay for this service.***

CANCELLATION AND NO CALL/ NO SHOW POLICY:

Please allow 24 hours' notice when canceling appointments. Less than 24 hours' notice will be counted as a no show due to the length of the appointment and the lack of sufficient time to fill the appointment. 2 NCNS will result in termination of counseling services.

Consideration for modification of this fee schedule will be made on a case-by-case basis.

______________________________ ______________________

Name/ Date

Your signature states that you have been made aware of this policy. Please sign even if you feel that this will not apply to your situation.

I have read and understand the Financial Policy and office procedures at American Health Network. I agree to the cancellation/reschedule policy. I further understand I will need to make my co-pay at each visit. I acknowledge that I have either received a copy of this policy.

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Client Name (please print)

__________________________________ ____________________

Client Signature Date

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If the client is a minor, the Guardian must sign below:

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Guardian Name (please print)

__________________________________ __________

Guardian Signature Date

__________________________________ __________

Witness Date