

**Catholic Charities Counseling Services
2010 Client Payment Agreement-Fee**

1. **FEES:** The fee for a Diagnostic Interview is \$140 and for each counseling session is \$125 per 50-minute hour. Phone consultations will be billed in 15 minute increments at our standard rate of \$125 per hour. For those clients without mental health insurance, a sliding fee scale is available. Fees on the sliding scale are determined by income and family size. Please check the gross (before taxes) annual family income range that applies and provide supportive documentation (W-2 or check stub).

0 - 5000	_____	30001-32500	_____	55001-57500	_____
5001-10000	_____	32501-35000	_____	57501-60000	_____
10001-13500	_____	35001-37500	_____	60001-62500	_____
13501-15000	_____	37501-40000	_____	62501-65000	_____
15001-17500	_____	40001-42500	_____	65001-67500	_____
17501-20000	_____	42501-45000	_____	72501-75000	_____
20001-22500	_____	45001-47500	_____	67501-70000	_____
22501-25000	_____	47501-50000	_____	75001-77500	_____
25001-27500	_____	50001-52500	_____	70001-72500	_____
27501-30000	_____	52501-55000	_____	77501-80000	_____

Please indicate the size of your household (include dependents you are financially responsible for but do not live with you) _____.

2. **PAYMENTS:** I agree to pay my fee on the date of service. I understand that I may not carry more than the balance of two appointments at any time. I understand that I will not be allowed to schedule another appointment if I have an unpaid balance for 2 visits, unless other payment agreements have been reached with the business office. I understand that the agency utilizes a collection agency for non-payment of client fees.

As applies, I agree to pay _____ per 50 minute hour for individual or family counseling
 _____ for group counseling
 _____ for psychiatric evaluations and
 _____ for medication checks.

3. **CANCELLATIONS/NO SHOWS:** I understand that I will be expected to pay \$20 for an appointment that I do not cancel 24 hours in advance. I understand that I will not be allowed to schedule another appointment if I cancel with less than 24 hours notice or “no show” for two consecutive appointments or three appointments in a month unless I pay \$20 for each broken appointment prior to rescheduling. Cancellations and “no shows” represent a loss of opportunity to the agency to serve you and offer services to other clients.
4. **INSURANCE:** I understand that I will be responsible for the full \$140/\$125 fee if I have insurance that will cover services at this agency but I choose not to use it.
5. **Updates:** I understand that I will be expected to update my financial and family information at least every six months and that the terms of this agreement may change dependent on changes in my situation.
6. By signing below, I certify that the above information I have provided is correct.

_____ Name- Please Print	_____ Name-Signature	_____ Date
_____ Spouse-Please Print	_____ Spouse-Signature	_____ Date
_____ Witness-Please Print	_____ Witness-Signature	_____ Date