Catholic Charities Counseling Services
2010 Client Payment Agreement-Insurance

1. FEES: The fee for Diagnostic Interview is $140 and 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. I agree to be responsible for the payment of these fees as they apply.

2. PAYMENTS: **I agree to pay my co-pay, or toward my deductible, whichever is applicable, on the date of service. 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.**

3. **CANCELLATIONS/NO SHOWS**: I understand that I will be expected to pay $20 for each appointment for which 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 am responsible for knowing the terms of my insurance coverage and for monitoring the accuracy of insurance payments. I understand that benefits quoted are NOT a guarantee of payment. If there are any questions regarding benefits I will contact my insurance company prior to my counseling session. I understand that Catholic Charities will file my insurance claims as a service to me. I understand that I will be responsible for the **full fee** if I do not comply with any of the number of requirements my insurance company may make of me such as securing prior authorization for treatment. I also understand that I will be responsible for the full fee if I have insurance that will cover services at this agency, but I choose not to use it.

5. INSURANCE PAYMENT OF BENEFITS: I authorize payment of benefits to be made on my behalf to Catholic Charities Counseling Services.

______________________	______________________	__________
Name- Please Print	Name-Signature	Date
Spouse-Please Print	Spouse-Signature	Date
Witness-Please Print	Witness-Signature	Date

FOR STATISTICAL PURPOSES ONLY: We are required to gather information noting the income ranges for ALL clients. PLEASE INCLUDE GROSS (BEFORE TAXES) ANNUAL FAMILY INCOME FROM ALL SOURCES:

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	________