ASSURANCE COUNSELING, LLC - SERVICE FEE AGREEMENT

CLIENT NAME: ____

TYPE OF INSURANCE

PRIMARY INSURANCE: __________________________

SECONDARY INSURANCE: __________________________

DEDUCTIBLE: __________________________

CO-PAYS: INTAKE SESSION: ______________________________________

INDIVIIDUAL SESSION: ______________________________________

FAMILY SESSION: ______________________________________

PRIVATE PAY FEE: _________________________

(1) **PRIVATE FEES, CO-PAYS, AND DEDUCTIBLES ARE TO BE PAID AT THE TIME OF SERVICE.** Payments will be collected the day of service.
(2) Balances are not to exceed the fee of one session
(3) Therapist reserves the right to discontinue service should there be continuous lack of payment on balance.
(4) All insurance deductibles must be met.
(5) Any legal custodian of a minor who brings the minor to therapy is responsible for payment on co-pays/deductibles/private fees.
(6) CANCELLATION/NO-SHOW POLICY:
    Clients who do not cancel their scheduled appointment 24 hours prior to the appointment will be billed for their therapist appointment.
(7) Therapist charges a fee of $25 to complete forms that clients request be completed. If the form is submitted for completion less than 24 hours before it is due, the fee is $40.00 per hour. Such forms are, not limited to FMLA Disability, Employment/Human Resources/Personnel, Court.

Client's signature, or responsible adult's, is the agreement of Benefits to Assurance Counseling, LLC (Latresa L. Williams, BSW, ACSW, LMSW); and, the agreement to pay all deductibles, co-payments, and/or non-covered services.

I have been given the opportunity to read this agreement. I understand and agree to the conditions specified herein.

____ _______________________

Client/Parent/Legal Guardian Signature Date

____ _______________________

Witness Signature Date