Inner Guidance Counseling Center, PLLC
FEE AGREEMENT

Client Name: _____

Insurance: _____ Private Pay: _____

Co-Pay and Deductible Information: _____

Sessions per year: _____

Fees:

Service Type	Insurance Rate	Client Co-Pay	Private Pay Fee:
Intake	_____	_____	$150.00
Individual Session	_____	_____	$130.00
Family Session	_____	_____	$130.00
Psychological Testing	_____	_____	$200.00
No Show/Late Cancel		$ 75.00	

Other fee related information: _____

Inner Guidance Counseling Center, LLC (IGCC) participates with some direct pay insurance companies and the stated fees shall be in accordance with the contractual amounts. The amounts stated as "Client Co-Pay" is subject to change based upon changes in rate or the exact amount which is paid to the clinic when services are rendered. Fees to be assessed once benefits have been exhausted should be reached between the responsible party and therapist, when necessary. I, the undersigned, agree that regardless of insurance status, I am responsible for the balance on my account for all professional services rendered. I understand that the insurance policy is between me and my insurer and IGCC is not responsible for payments made by the insurance company. I am aware that I am responsible for all fees when the insurance company does not pay or pays an amount different from that stated in the agreement. I am responsible for notifying IGCC of any changes regarding my insurance and failure to do so may result in my being responsible for the total cost of services.

Additionally, I understand that a **minimum of a 24 hour notice** is required when canceling or not attending a session, and that failure to give this notice will result in a charge for that session. Missed appointment charges are **not covered by insurance.**

_____ _____
Client/Parent or Guardian Date

_____ _____
Witness Date

Revised 10/7/19