FEE AGREEMENT

I understand that I ,_____, am responsible for payment of session fees at the time of service to

Mindy Haber LCSWR, CASAC

I understand that I am responsible for

- A $30.00 fee for any returned check.
- Session fees for missed/cancelled sessions if I do not cancel at least 24 hours prior to my scheduled appointment.

I am not responsible for any session fees when the session is cancelled by the therapist.

Session Fees may be paid in cash, check or credit card.

The following are the fees for treatment services:

Intake – 90 min	$160
Individual – 45 min	$100
Individual – 30 min	$ 70
Family- 45 min	$100
Parent guidance- 45 min	$100
Parent guidance- 30 min	$ 70
Group- 45 min	$TBD
Group- 30 min	$TBD
Court documents/letters	$100 per hr.
Attendance in collaborative meetings	$100 per hr.
Phone consultations	$50 per 20 minutes
Fee to appear in court	$1,500

- Fees may be changed at the therapist's discretion. Any change to the client's fee will be discussed with the client prior to change and noted above on this agreement.

Please note that some services are not covered by insurance plans.

Utilizing Insurance Benefits-

In the case that my insurance company has authorized payment toward session fees, I understand that I am responsible for the copay as stipulated by my insurance coverage. My copay is _____. This copay is due at the time of the session. If authorization/payment is denied by the insurance company, the session fee is then my responsibility and is due at the time of session. If my copay/insurance coverage changes I will inform my therapist immediately.

_____ _____

Client/Parent/Guardian Signature Date

_____

Witness/Therapist