

LifeLine Professional Counseling Services
 2460 W. Ray Rd., Suite 1
 Chandler, AZ 85224
 Tel: 480.641.1165 Fax: 480.641.9026

Clt Name: _____ Clt ID #: _____ Today's Date: _____

Financial Information and Agreement

<u>Fee Schedule:</u>	<u>Counselor</u>	<u>Doctor</u>
Initial Assessments/Intake appointment (60-70 min.)	157.50/HR	168.00/HR
Therapeutic Intervention/Office Visit (50 min.)	105.00/HR	112.00/HR
Family/Couples/EMDR Session (60-70 min.)	157.50/HR	168.00/HR
Telephonic Consultation (billed in 6 min increments)	105.00/HR	112.00/HR
Correspondence w/ Attorneys, Parents, etc. (billed in 6 min increments)	105.00/HR	112.00/HR
Travel Time	75.00/HR	75.00/HR
Returned Check Fee (per occurrence)	\$35.00	
Late Cancellations/Missed Appointments (*see note below)	Time Reserved	
Copies/Faxes Received over 15 pages	\$0.50/page	

*Late Cancellations/Missed Appointments. Fees are applied at the stated hourly rate. Patients must sign a debit/credit card form which is kept on file for this purpose.

Client/Parent Initial _____ **Spouse/Other Parent Initial** _____

Courtesy or Second Party Payors. Please understand that the Patient/Parent is responsible for paying ALL fees. This office will allow a courtesy payor or a second party (ie adult parent paying for an adult child) to pay for services, however, we will not discuss appointments or appointment schedules with courtesy payor because of confidentiality. Payments must be made with a signed debit/credit card kept on file. Other billing options are not available for courtesy payors.

Client/Parent Initial _____ **Spouse/Other Parent Initial** _____

Outstanding Balance. Any accounts with a balance outstanding longer than 30 days will accrue interest at the rate of no less than 10% per month. If necessary this office will utilize the services of a collection agency where the patient/parent is responsible for all fees associated with collection.

Client/Parent Initial _____ **Spouse/Other Parent Initial** _____

By my signature, I acknowledge reading and agreeing to the above financial terms.

Signature _____
Date

Signature _____
Date

I authorize Lifeline Prof. Counseling Services to charge my credit card for any fees/balance owed including missed appointments. Charge fees/balance to the following credit card: *see attached cc form

Client/Parent Initial _____ **Spouse/Other Parent Initial** _____