Aspen Counseling Services, PLLC

TREATMENT AND FINANCIAL CONTRACT

1- INFORMED CONSENT

I hereby request and consent to treatment by any therapist or counselor who provides services on behalf of Aspen Counseling Services. I understand that I will have the opportunity to discuss the nature and purpose of counseling procedures with the therapist. I understand that results of therapy are not guaranteed. By signing below, acknowledge that I understand and agree to the foregoing. I intent this consent form to cover the entire course of treatment at/with Aspen Counseling Services for my present condition and for any future condition(s) for which I seek treatment.

2- CONSENT FOR TREATMENT OF A MINOR

I, the undersigned, as a parent or guardian of _____ (please print name) a minor child, herby authorize the counselor and whomever he/she designates as his/her assistants, to administer treatment to my child as necessary. I also acknowledge and agree to the terms set forth in Section 1 and Section 5 on behalf of the minor child.

3- HIPPA

By signing below, I understand that I am in receipt of the Aspen Counseling Services HIPPA notification and fully understand it and my rights (or my minor child's rights) per the document.

4-COURT APPEARANCE

Court Appearance: Clients are discouraged from having their therapist subpoenaed. Though the client's attorney, who initiates the subpoena request is responsible for the court appearance and testimony fees, it does not mean that the therapist's testimony will be solely in in the client's favor. Your therapist will only testify their professional opinion and to the facts of the case.

The following fees apply for court appearances:

Preparation time (including submission of records)	$220/hour
Phone calls	$220/hour
Depositions	$250/hour
Email or written letters	$200/hour
Time required in giving testimony	$250/hour
Mileage	$0.54/mile
Time away from office due to depositions or testimony	$220/hour
Filing a document with the court	$100 (Plus court fees)
The minimum charge for a court appearance	$1500

PLEASE NOTE: A retainer of $1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice there will be an additional $250 "express" charge. If the case is reset with notice of less than 72 business-hours, the client will be charged $500 (in addition to the retainer of $1500).

5 – FINANCE POLICY

Insurance: We participate in several insurance plans. If you are insured by a plan we are in network or have a contract with, but don't have an up-to-date insurance card, payment in full is required until we can verify your coverage. Knowing your insurance benefits are **your** responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If your insurance changes, please notify us before your next visit so we can make sure the appropriate changes are made to maximum your benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you

All patients must complete our patient information forms before seeing the therapist. We must obtain a copy of your driver's license, and current insurance card for proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the full balance of the claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

Co-payments & deductibles: All copayments and deductible must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments & deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payments at each visit.

Past due accounts: If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If this is to occur, you will be notified by that you have 30 days to find alternative medical care. During that 30-day period, our therapist will only be able to treat you on an emergency basis and you will have to pay for the session in full prior to the appointment.

Cancelation & Late, No-Show Policy: Clients can cancel or reschedule anytime as long as they provide a 24-hour notice. Failure to do so you will be charged for your session **Our Fee is** $100.00. If you are 10 minutes late you will be asked to reschedule. These charges are your responsibility and cannot be billed to insurance.

New Clients: If you do not show for your first session, you will be moved to bottom of waiting list which is approximately 4-6 weeks.

Letters: If a disability letter, companion pet letter, or letters regarding your ability to work is required attesting your needs, the therapist will provide it for a fee of $35 per one-page letter and $25 for each additional page. Letters are only provided to clients who have been seen for 6 sessions or longer.

**These fees are subject to an increase at any given time.*

. ***I have read & understand the payment policy. I agree to abide by its guidelines.***

Printed Name: _____

X _____ _____

SIGNATURE *DATE*