COUNSELING FEE AGREEMENT

Family Houston charges a fee of $125.00 for a 45 minute individual or family counseling session. We also accept insurance. You may be eligible to receive these services at a reduced fee that is subsidized by United Way funds. Your statement of family income must be verified with a copy of your most recent tax return or a recent pay stub. A sliding scale fee is then determined based on income and family size. You are responsible for a *sliding scale/co-payment* of $_____ per session for the counseling services you receive.

- Service fees are payable at the time services are rendered. If you cannot pay at that time, you will be offered an opportunity to reschedule your appointment.
- Family Houston does not extend personal credit. Payment must be made in the form of cash, personal checks, or credit cards (MasterCard or VISA).
- There is a $9.00 charge for every returned check. After two check returns, only cash or credit card payments will be accepted.
- You will be responsible for a payment of $25.00 for appointments cancelled with less than 24 hours notice, except in the case of emergencies. This is applicable to <u>all</u> clients.
- You will be responsible for informing Family Houston of any changes to your insurance, Medicaid or Medicare. If you fail to do so any charges incurred that are not covered will ultimately be your responsibility.
- <u>If you have your therapist subpoenaed, you will be billed at the rate of $125.00 for each hour the therapist is required to be available</u>. Such fees are payable at the time services are provided. Unpaid balances for these services must be paid before services can continue.

I have read this agreement and understand that I am responsible for payment of the fee as described above. I authorize the release of any information necessary to process claims to my insurance plan and/or to the insurance plan of individuals for which I am legally responsible. I authorize payment for services to be made directly to Family Houston, less any co-pays or deductibles for which I am responsible. I acknowledge having received written descriptions of the program, my rights, grievance procedures, and the Notice of Informational Practices. By signing below, I give my consent for treatment within the Individual and Family Counseling Program.

_____

Client's Signature Date

_____

Staff Member's Signature Date

Client Name (please print): _____ Client ID: _____

Staff Name (please print): _____