Counseling & Evaluation Services Fee Agreement

EFR EMPLOYEE & FAMILY RESOURCES

Counseling Session Fee: EFR's standard counseling fee is $165 per 45-60 minute session. EFR accepts various forms of insurance and third party payers. If your health insurance doesn't cover EFR's services or if your services aren't eligible for health insurance or third party payment, your fee will be based on EFR's sliding fee scale, which considers your gross family income and the number of family members in your household.

Payment Policies

- Payment of your fee or insurance co-pay and/or deductible is required at the time of service unless other arrangements have been made with EFR.
- If your insurance carrier or other third party payer doesn't pay for your services, EFR may charge your services in accordance with our sliding fee scale and you may be responsible for any unpaid services.
- Lack of payment toward an unpaid balance (excluding outstanding insurance payments) may result in an interruption in services until payment arrangements are agreed upon.
- You will be charged $30 for returned checks.
- Cash, check, or debit/credit card are accepted.
- ***We encourage you to inform your provider or the EFR Clinical Director if assistance is needed in developing a payment plan.***

Cancelled and missed appointments

A 24-hour notice is required for cancellations. Failure to provide 24-hour notice <u>may</u> result in a charge of $25 for the missed appointment or the amount of your private pay fee, whichever is less.
Please initial here to show acknowledgement of this policy: _____

<u>Insurance Information</u>

Primary Company_____

Subscriber Name_____

Subscriber #_____

Employer Group #_____

Co-Payment/Deductible_____

SS#_____

Secondary Company _____

Subscriber Name_____

Subscriber #

Employer Group #

Co-Payment/Deductible_____

<u>Statement of Understanding and Agreement</u>

I,_____ verify that I understand and agree to abide by the policies noted above. I authorize EFR to release to my insurance company(s) my session dates, demographic information, method of treatment, and diagnosis as required for the purpose of processing and paying my claims. I also authorize EFR to obtain insurance reimbursement directly from my carrier. If I'm not accessing insurance or another third party payer, I agree to pay a fee of $_____. I understand that this agreement will be reviewed annually and/or when my financial circumstances change (if my income and/or other financial circumstances were used in determining my fee). I understand that the current agreement supersedes all previous fee agreements.

_____ _____
Client Signature Date

_____ _____
Representative authorized to sign in lieu of client Date

_____ _____
EFR Representative Date