Fee and Payment Agreement

I, _____, agree to pay Lisa Inoue, LMSW PLLC the private pay fee of $_____ per session (60 minutes) for psychotherapy services for myself/child given her non-participation with my insurance company or my desire to not utilize my insurance benefit for my mental health treatment. In the event that I choose to use my insurance coverage and Lisa Inoue LMSW PLLC is a participating provider, I understand that my co-pay is $_____. Sessions that exceed 60 minutes for will be prorated at the agreed upon rate of $_____ for those paying out-of-pocket fees. I understand that payment of the agreed upon fee, or insurance co-payment, will be made at the time of service unless other arrangements are made. I further understand that I am responsible for paying all balances not paid by my insurance company within 30 days, and I hereby agree to allow the release of basic information to a collection agency should I fail to pay any outstanding balances. I agree to pay any and all fees incurred by Lisa Inoue, LMSW PLLC that may be necessary to collect any unpaid balances after reasonable notification that I have an unpaid balance.

If I am using insurance, I understand that it is my responsibility to verify coverage, learn what my co-pay (if applicable) is, and find out what limitations of coverage exist (e.g., deductible, session limits, pre-authorization requirements, etc.). I realize that some insurance companies contract out their mental health coverage to another company, e.g., Blue Cross Blue Shield may contract out their mental health coverage to Magellan. In such a case, I may be responsible for an out-of-network rate even though Ms. Inoue is in network for my main insurance. If the insurance company does not pay for a service, I will pay for that service.

I understand that Lisa Inoue LMSW PLLC reserves the right to bill me at the prorated rate of $_____ should she need to participate in phone calls exceeding 15 minutes in length, with myself, my child or someone cooperating with myself or my child's treatment.

I also understand that Lisa Inoue LMSW PLLC reserves the right to bill me at the prorated rate of $_____ for any paperwork that she may need to complete on my or my child's behalf that cannot be completed within our session time.

I further understand that I am required to give 24-hour notice in order to cancel my psychotherapy appointment. I hereby agree to pay the *fee of $60* for any appointments that I fail to cancel 24 hours in advance. An exception to the requirement to give 24 hours notice will be made the first time it occurs. The missed appointment/late cancellation fee is due within seven days or at the next appointment, whichever is sooner. I understand that my insurance company will not pay for missed appointment or late cancellation charges.

Agreement

By signing below, you agree that you have read this agreement and consent to its terms.

Client Name

Client Signature
(or signature of parent/guardian)

Date

Witness Signature

Date