MASTERPEACE

Center for Counseling and Development

Acct # ___________

Scan Date ___________

FEE AGREEMENT

MASTERPEACE charges fees for each session and according to the professional providing the services. The fee schedule is as follows:

COUNSELING	INITIAL SESSION FEE	FOLLOW-UP FEE
MASTER'S (LMSW)	$140	$110
PHD/ SUPERVISED LMSW	$160	$130
LATE CANCEL/NO SHOW FEE		$40
TESTING	**2 HOUR FEE**	**4 HOUR FEE**
PHD/ SUPERVISED LMSW	$260	$510
NEUROFEEDBACK	**1 - VISIT**	**10 - PREPAID VISITS**
PHD	$75	$600
ADMINISTRATION FEES	**COMMUNICATION / CORRESPONDENCE**	**OTHER PROFESSIONAL SERVICES**
LMSW	$100	$150
PHD	$120	$175

A 45 to 60 minute session will be **charged** at the **applicable amount above.** The client, parent, or guardian listed below will be responsible for paying all co-pays, deductibles, and other charges as required by the insurance company. The client, parent, or guardian understands that the "usual and customary" rate approved by the insurances is not a guarantee of payment. The client's actual out-of-pocket expense may be more than the co-pay amount alone (i.e. deductible must be met in full). The client further understands that any insurance benefits received by MASTERPEACE will be credited to the client's account and that if the insurance company pays the client directly the client will owe MASTERPEACE the entire amount.

The client, parent, or guardian agrees to accept full responsibility for payment for all services rendered, including deductibles, co-pays, and any amount denied by the insurance company.

MASTERPEACE Counseling reserves the right to charge the LATE CANCEL / NO SHOW Fee of $40.00 if the client neglects to cancel an appointment 24 hours in advance.

MEDICAID CLIENTS

Client, parent, or guardian will be responsible for payment of fees that are not a covered benefit of the Medicaid plans. (Example of non-covered services: court ordered counseling, Late Cancel/No Show fee of $40.00, or sessions beyond what Medicaid authorizes, etc.)

RELEASE OF INFORMATION FOR REIMBURSEMENT OF SERVICES

MASTERPEACE will release information to the client's insurance company or any other entity providing reimbursement of services:

1. To determine eligibility and process claims for benefits submitted on behalf of the client or the client's dependents.
2. This signature will bind the client to authorize the therapist to submit claims for services rendered, without having to obtain the client's signature on each and every claim.
3. To authorize the client's insurance company or any other entity providing reimbursement of services to pay and assign directly to MASTERPEACE all benefits for services as described.

CLIENT'S APPROVAL OF FEES AND RELEASE OF INFORMATION

I, the undersigned, acknowledge that I have the legal authority to agree to the above terms and will inform MASTERPEACE immediately if the authority changes.

_______________________________________ _______________________

Signature *(Parent/Guardian must sign if client is under 18 years old)* Date

_______________________________________ _______________________________________

Print Client's Name Print Parent/Guardian Name (if minor)

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✦ ✦ ✦ ✦ CLIENT'S COPY ✦ ✦ ✦ ✦

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