Advanced Counseling and Testing Solutions, LLC

2121 Oregon Pike, Suite 201
Lancaster, PA 17601
T: 717-208-6599 F: 717-208-7753
www.ACTSofLancaster.com

4 Wellington Blvd., Suite 101
Wyomissing, PA 19610
T: 484-987-7116 F: 484-509-4962
www.ACTSofReading.com

Fee Agreement and Cancellation Policy

By signing this document, I am entering into a contract with Advanced Counseling and Testing Solutions, LLC regarding payment of fees for services rendered.

1. FINANCIAL RESPONSIBILITY: I acknowledge full financial responsibility for services rendered at Advanced Counseling and Testing Solutions, LLC. Payment of these charges is collected at the time of service. I understand that any charges incurred by Advanced Counseling and Testing Solutions, LLC associated with collection of payments (e.g., insufficient funds, collection cost, denial of insurance benefits) will be forwarded on to me.

2. CANCELLATION / NO SHOW POLICY: Appointments that are canceled with less than 48 hour notice typically cannot be filled with other clients, any cancellation made with less than a **48 hour notice (not including weekends)** or any appointment missed will result in the client being charged for the appointment. **Rates are $85 for appointments canceled with less than 48 hours notice and for appointments missed without notification.** These charges are not billable to any insurance company. Appointments canceled due to inclement weather, will not incur a charge.

3. SERVICE TERMINATION: I understand that if I do not make payments for services at the time of service, Advanced Counseling and Testing Solutions, LLC reserves the right to suspend treatment, upon appropriate notice, and will assist in making a referral elsewhere.

4. BILLING: A billing statement covering your services will be mailed to you each month. We expect payments to be made on a timely basis. A past due account will be turned over to our collection agency if no payment has been made.

5. ADDITIONAL FEES: I understand that if my (or my child's) clinician is asked to appear in court either as an expert witness or subpoena/IEP meetings/or any other circumstances requiring either in-person or virtual appearance of my clinician on my behalf the fee is $250 per hour with a 1 hour minimum fee of $250. If during a court appearance the clinician is not called for several hours, you will be charged from the requested arrival time. I understand that if my clinician is asked to write a legal document/statement on my (or my child's) behalf the fee is $175 per document request.

6. COLLECTIONS: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. You agree, in order for us to service your account or to collect monies you may owe, Advanced Counseling and Testing Solutions, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

7. INSURANCE: Your specific policy is an agreement between you and your insurance company. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than you anticipated (i.e. deductible).

8. MINOR PATIENTS (UNDER 18 YEARS OF AGE): The parent/guardian/adult accompanying a minor child is responsible for full payment. If both parents have insurance, the parent with the first birthday is most often the primary insurance. Please check your insurance policy to determine which company is primary before your appointment. In divorce cases, we will bill our participating insurance, but the parent who brings the child in for services is ultimately the responsible party.

9. COPY OF CHART: There will be a charge of $35.00 for anyone who requests a copy of their chart, contents are up to the discretion of our clinical director and due to privacy laws, session notes will not be provided without a court order.

I have read, fully understood, and agree to the above fee agreement and cancellation policy.

Client's Name:

_____D.O.B._____

Responsible Party's Name:

_____

Responsible Party's Signature:

_____DATE:_____

Responsible Party's Social Security #:

_____

Helping clients is our mission, not only our profession!