Payment Responsibility

Patient Name: _____ Date of Birth: _____

Intake Appointments	$100 / session
Individual Therapy	$75 / session
Group Therapy	$75 / session
Family/Couples Therapy	$125 / session
Subpoena to Court for Expert Testimony Non-Refundable Up-Front Retainer	$500 / one-time fee
Court Appearance and Preparation	$200 / hour
Additional Expenses for Court	TBD
Additional Practice Fees	TBD on a case-by-case basis

I understand that I am responsible for charges incurred for services rendered as part of my (or my child's) treatment. I shall pay these charges at the time services are provided unless alternative arrangements are made. I authorize payment of medical benefits directly to Revelation of Hope Counseling Services, LLC or my assigned provider for any third party benefits (insurance, etc.) to which I am entitled. I understand that insurance benefits paid to Revelation of Hope Counseling Services, LLC will NOT reduce my payment responsibility unless the insurance benefits and my payment responsibility combined should exceed the standard fee charged by the agency. In such event, the excess will be used to reduce my responsibility or if my account has been paid in full, will be refunded to me.

I further authorize the release of information needed to process third party claims. If I choose to be the payee of the insurance benefits or refuse to allow my insurance to be filed, I will be responsible for payment of the standard charge for services.

I also understand that 1.5% interest per month will be charged on all unpaid accounts. I understand that Revelation of Hope Counseling Services, LLC reserves the right to use established collection procedures if I do not meet my payment responsibilities and that any collection fees will be added to my account.

Employer (or student): _____ ☐ Unemployed

Household Size: _____ Annual Gross Household Income (All Sources): _____

	First Funding Source	Second Funding Source
Insurance Co. Name		
Insurance Co. Address		
Insurance Co. Phone #		
ID # / Group #		
Cardholder's Name		
Address		
Phone #		
SSN		
DOB		
Relation to Client		
Employer		

Any deviations from the above fee schedule are indicated here: _____

Patient Initial: _____ Staff Initial: _____

_____ _____
Patient Signature Date

_____ _____
Signature of Patient's Authorized Representative Date

_____ _____
Signature of Staff Reviewing Date