MURRAY, WILSON & ROSE
COUNSELING AND BEHAVIORAL SERVICES

Financial Policies and Procedures

Please initial each section to confirm understanding of the financial policies and procedures of Murray, Wilson & Rose Counseling and Behavioral Services, LLC (MWR Counseling). Please note, if not initialed, the MWR clinician and/or office coordinator will review with you verbally. *If you choose not to acknowledge understanding, this does not exclude client from financial responsibility.*

_____ FEES AND PAYMENT:

MWR's fee for a 60-minute session is $150.00; 45-minute session is $130, and 30-minute session is $95.00. The initial intake appointment fee is $175. The fee or co-payment will be collected from you at the time of the session. If we decide on a different time frame, fees will be prorated accordingly. If you use your insurance, I will accept their rate of payment, collect any co-payment at time of session, and bill the insurer. You are responsible for knowing what your benefits are, and for payment of any fee or part of a fee that the insurer does not pay, and are responsible for that payment. I reserve the right to assess a finance charge on past due bills, or in extremely delinquent cases to turn them over for collections. ***If you require paperwork such as FMLA, ADA, Disability, etc. to be filled out as part of your treatment, there is a fee of $35 per occurrence for this service that is billed to you directly, not through insurance. This will be due prior to paperwork being sent out.***

_____ CANCELLATION POLICY:

MWR clinicians make every effort to accommodate as many clients as possible during the times available during the week. For that reason, it is necessary to have a cancellation policy that is fair and reasonable for all concerned. Please try not to miss sessions if you can possibly help it. A cancelled appointment delays our work. When you must cancel, please give me notice by telephone or email at your earliest convenience. **You will be billed a $50 late cancellation fee for *same day cancellations*. This applies to any appointment that is cancelled on the day you are scheduled to be here**. If you have three occurrences where you do not show up for appointments and do not provide adequate notice, I reserve the right to terminate counseling and refer you to another therapist.

_____ Client is responsible for knowing insurance benefits and coverage. MWR Counseling submits claims to insurance carrier as a courtesy and cannot guarantee benefit information that they have been given.

_____ Client is responsible for payment of copay, coinsurance, or deductible amount at time of service. If copay or coinsurance amount is unclear, client will be subject to a visit fee of $30. If insurance pays fee in full, MWR Counseling will refund visit fee to client.

_____ If client is a minor, responsible party will need to make arrangements with Cindy Scott, MWR Counseling's office manager, to determine how copayments will be made at time of service.

_____ If there is a balance on the account, paper statements will be mailed the first week of each month. Remaining balance is due upon receipt of statement and no later than the 28th of the month.

_____ MWR Counseling reserves the right to suspend/terminate treatment if client balance reaches $300 and appropriate arrangements have not been made. MWR Counseling will provide referral information to local agencies or providers that offer financial assistance in the form of sliding fees.

_____ Checks returned for non-sufficient funds will result in a $35 charge to client account.

_____ MWR Counseling reserves the right to send client accounts to collections if payments have not been made in 60 days.

I acknowledge that I have received Murray, Wilson & Rose Counseling and Behavioral Services fees, cancellation policies, billing/payment policies and procedures. I acknowledge that I have read the above information and clarified any questions or concerns. I understand that I have a right to a copy of this information.

Client Name:_____Signature:_____

Parent/guardian_____Date_____

Witness/CLINICIAN:_____Date_____

I would like to receive a copy of this disclosure statement ____Yes _____decline