HIGHWIRE THERAPY, LLC

ALLISON STAIGER, LCSW, TIYT

Financial Agreement

Please initial by the appropriate option:

_____ I am choosing to have my therapy services reimbursed by medical insurance carrier or 3rd party. I understand that by signing this form I am allowing Allison Staiger, LCSW to provide required information to assure reimbursement for services she may render. Information could include diagnosis, treatment plans, goals/objectives and, in some mental health coverage plans, copies of the progress notes. The therapist would alert you to progress notes requests. I understand that an applicable DSM-V diagnosis is required for use of insurance. Claims that are denied due to lack of coverage will be the patient's responsibility.

_____ I have insurance, but it is out of network for this provider. I agree to pay all services at time of service and understand that it is my responsibility to file with my insurance carrier, if those benefits exist. The therapist will provide a monthly superbill upon request.

_____I do not have insurance, or I am choosing not to use my insurance. I am paying out of pocket for counseling services. I agree that I will not bill my insurance now or in the future for the sessions already attended in the current course of treatment.

Payment is due at the time of service, by cash, check, or charge. A balance may not be carried on my account. Accumulation of a balance will result in disruption of treatment. An active credit card will be kept on file. By signing, I am indicating that I have entered my credit card information into the Client Portal, or that I will provide it to my clinician via a paper Credit Card Authorization form.

An active credit card will be kept on file. By signing, I am indicating that I have entered my credit card information electronically via the Simple Practice Client Portal (or that I will provide it to my clinician via a paper Credit Card Authorization form), and that my clinician is authorized to use it for payment.

Fees and Services: Services are provided for the following fees:

- Initial Intake session (up to 90 minutes), $150
- Individual Therapy Session (50-55 minutes), $110
- Parent Consultation (50-55 minutes), $110

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- Additional services, such as school visits, involvement in hearings or depositions, extended report-writing, etc., have a separate fee schedule, which would be provided as needed.
- Currently, there is no charge for brief phone calls between visits. However, should this policy be taken advantage of, clinician reserves the right to re-evaluate. Client will be told before this happens. Phone calls longer than 15 minutes will be billed at a prorated amount.

A 24-hour cancellation notice is required. Failure to provide adequate notice will result in a fee of $80.

Any increases in the fee schedule will be submitted to the client in writing 60 days before change will go into effect.

Responsible Party Signature:_____

Printed Name: _____ Date: _____

INSURANCE INFORMATION (if applicable):

Client's Name: _____ DOB: _____

Policy Holder's Name: _____ DOB: _____

Insurance Company: _____ Phone: _____

Member ID #: _____ Group #:_____

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