Compass Counseling and Consulting Services LLC

FINANCIAL RESPONSIBILITY POLICY FORM

General provisions

1. Fees for therapy are based on 45-50 minute increments of the provider's time. The provider may bill the client for time spent related to the client that is not face-to-face, including telephone calls, records review, preparing documents, printing documents, writing reports, including letters requested by school, or outside resources, court appearances, etc.The provider will discuss the fees as they apply in your case as soon as is feasible.
2. I accept cash, personal checks, or debit/credit cards. There is a fee of $30 for each bad check billed to the client.
3. Any fees incurred by our company while attempting to collect any delinquent fees or other delinquent charges for the client will be charged to the client. This includes, but it is not limited to:
    a. Any resulting fees from credit/debit card chargebacks and/or declined payments.
    b. Any resulting fees from collection agencies, or any other collection agent.

Out-of-network clients (self-pay)

1. All fees for services rendered to self-pay clients are due at the time of service.

No-shows and cancellations

1. I may provide reminder calls as a courtesy, but please do not count on them to remember your appointments.
2. Missed appointments (no-shows) will be billed in full to the client.
3. Cancellations made less than 24 business hours in advance of the date and time of a scheduled appointment are considered to be a late cancellation. Late cancellation fees will be assessed as follows:
    a. First instance: A fee of $25 will be assessed.
    b. Second instance: A fee of $50 will be assessed.
    c. Third instance: The full fee for the appointment will be assessed.
4. If a client has 3 or more no-shows or late cancellations, services may be terminated at our discretion.

I have read and accept the policies outlined above. I agree to assume the financial responsibility for services rendered. If using insurance, I authorize the provider to release the necessary information to my health insurance carrier. This financial responsibility policy form supersedes any previous financial responsibility policy form by our company.

Name:_____

Signature:_____

Date:_____/_____/_____