



STANDARD FEE FOR SERVICES

FEE AGREEMENT

I understand that the standard fee for services for individual psychotherapy is \$150 per 45-50 minute session or \$200.00 per 80-minute session. Other services are also available and these services and their associated fees are provided upon request. I further understand that unless another payment schedule is specifically arranged, the standard fee for services applies. Any revisions to these standard fees for services are indicated on the reverse.

I understand that if I am in a position to pay the standard fee for services, that I will do so. This enables *The Lovett Center, LLC* to provide adjusted fees to others who aren't able to do so. I also understand that if my situation changes at any point that I am invited to re-negotiate this fee with my therapist. In other words, at no time should my decision to participate in therapy be contingent on my ability to pay.

PAYMENT AGREEMENT

I understand that I will pay for all services provided either for myself or for my designee, _____ (name), _____ (relationship), at the time each session is rendered.

I understand that I may pay with cash, personal checks, money orders, or credit card, however, should my personal check be returned due to insufficient funds, I will be assessed a \$25.00 service charge and I will be requested to pay with cash, money order, or credit card thereafter. I realize that while my signature does not bind me to therapy, it does make me responsible for all charges incurred prior to my termination.

I understand that if I am not able to honor my financial commitment that this may be grounds for conversing therapeutically about financial issues, renegotiating my therapeutic contract, exploring alternative options, and/or terminating from treatment. I further understand that if I am not able to make a payment after a particular session that I may ask my therapist for an extension for another week. I agree to make every effort to remit payment within that time frame. I also understand that I may not have more than two unpaid sessions accumulated at any one time. If this should happen I understand that I will need to speak with my therapist in order to negotiate the next steps.

MISSED SESSION POLICY

I understand that unless otherwise indicated, I will be charged my full fee for any missed sessions or sessions cancelled with less than 24 hours notice. However, emergency circumstances are discussed on an individual basis.

LIMITATIONS OF CONFIDENTIALITY

I understand that if I am providing payment for a non-minor designee, I may not have legal access to any kind of privileged information about that individual including assessment information, diagnostic information, or therapeutic progress. By contrast, I do understand that if another party, such as an insurance company, is providing reimbursement for my therapeutic services, I authorize that individual or institution to be informed of my presence in treatment, details of my diagnoses and care, and/or my discharge from treatment. I also understand that there are further limitations to confidentiality discussed in the *Notice of Privacy Practices* or other agreements and am aware of these constraints.

USING INSURANCE OR THIRD PARTY PAYMENT SOURCES

I understand that in general, *The Lovett Center, LLC* encourages me to be personally responsible to my therapist for paying my fees at the time of service. In so doing, I recognize that I am actively participating and investing in the therapeutic process and am able to maintain a direct relationship with this investment. In addition, I understand that this type of arrangement ensures my confidentiality and further allows me, my therapist, and The Lovett Center clinical team to make decisions about my care that are in my best interest, rather than based on other factors such as type of diagnosis, eligibility periods, deductible amounts, and limitations on numbers of appointments.



At the same time, I understand that *The Lovett Center, LLC* recognizes that I may wish to use an out-of-network insurance plan, EAP program, Health Savings Account, or other such third party payer. I understand that although *The Lovett Center, LLC* does not belong to any insurance panels and therefore is not a preferred provider for any insurance companies or their policies, I will be able to request an invoice for the services I have received and the payments I have made so that I may submit these to my insurance

company for reimbursement. I further understand that *The Lovett Center, LLC* may work with me and other third party payment sources to enhance my access to these services and that such circumstances will be evaluated individually as they arise.

If I should choose to use a third party payment source, I understand that I am still responsible for direct payment to *The Lovett Center, LLC* and that no guarantees can be made in terms of my reimbursement by the third party payment source. However, *The Lovett Center, LLC* will work with me as much as possible to facilitate this process.

I understand that if I use insurance or another type of third party payment source that I authorize *The Lovett Center, LLC* to release and/or exchange any pertinent information with such entities in order to utilize these benefits. This information includes but is not limited to my presence in treatment, my progress in treatment, my psychiatric diagnosis, any assessment information, and my discharge plan. I understand that most third party payment sources, such as insurance companies, do not pay for missed sessions and thus I am solely responsible for these fees.

FEE SCHEDULE ADJUSTMENTS

The following reflects the adjusted fee schedule I have made with my therapist based on a therapeutic conversation about these services and my present life situation:

\$ _____ Fee for Individual Psychotherapy

\$ _____ Fee for Couple or Family Therapy

\$ _____ Fee for Group Psychotherapy

\$ _____ Other: _____

I have read the preceding information and I agree to the aforementioned terms.

Client Name: _____

Client Signature: _____ Date: _____

Therapist/Witness: _____ Date: _____