MT. PLEASANT COMMUNITY COUNSELING ASSOCIATES
Fee Agreement

Client Name: _____ Date:_____

The goal of our practice is to provide you with quality service at the lowest possible expense. Our fee for the initial session is **$180.00** and all subsequent sessions is **$150.00.** If your insurance company does not cover our services, we will write off a portion of your fee based on your family income using our sliding scale as follows:
(Please provide the counselor with your insurance card for billing purposes)

Annual Gross Family Income:	Fee:
$100,000 and above	$ 150
$70,000 and 99,999	$ 90
Below 69,999	$ 75

Misc. Expenses that may arise

Late cancellation fee or No-show fee	$ 35
Writing Letters for court or other purposes	$ 25
Court appearances or Subpoena's per hour	$ 130
(out of county – mileage at the state rate)	
Phone calls over 15 minutes	$ 15
Return check fee	$ 30
Sec of State Driver's License Eval	$ 225

Cost for copying records:

Initial search fee is $23.71**
Pages 1-20 = $1.19 per page
Pages 21-50 = $.60 per page
Pages 51+ = $.23 per page
**A Patient shall not be charged the initial fee for their own medical records. However, a patient can be charged the other permitted per page fees.

***Bills that are accrued over $100.00 must be paid in full before another session is scheduled.**

INSURANCE AUTHORIZATION

Insurance companies apply co-payment and deductible fees to client responsibility. Benefits quoted are not a guarantee of payment and are subject to the terms, limitations and eligibility of the policy for the date of service. Payments for services are due at the time of service.

I, the undersigned certify that I (or my dependent) have insurance with _____and assign directly to Mt. Pleasant Community Counseling Associates all insurance benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Mt. Pleasant Community Counseling Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. We are located at 500 S. Main Street, Suite B, Mt. Pleasant, Michigan 48858. Our tax I.D. No. is: 38-3387304.

I understand that Mt. Pleasant Community Counseling Associates may be able to bill my insurance company. If not, I understand that it is my responsibility to pay for each session at the time of service, and to contact my insurance company for reimbursement. I understand it is my responsibility to know my insurance benefits, and it is my responsibility to pay for counseling services if my insurance does not. I also understand that my fee will be **$150.00** if covered by insurance or $_____ (see chart above) if based on a sliding scale fee. I understand if I do not attend my scheduled appointment and have not given at least 24 hours advance notice, I may be billed $35.00.

_____

Responsible Party Signature Relationship Date

_____

Client/guardian/print Counselor Date