CLIENT FEE AGREEMENT
Partners in Family Wellness, PLLC

Client's Name: _____ **DOB**: _____

I acknowledge that I am financially responsible for all services provided by Partners in Family Wellness, PLLC to the above named client.

☐ Section I: Agreement to Permit Billing for Third-Party Payments:

1. I understand that the fee for services I receive from Partners in Family Wellness, PLLC (PFW) will be charged to third-party payer(s) in accordance with the terms of my insurance policy and PFW's contract with my insurer.

2. I understand that if I am insured by a private, for profit insurer, I may be charged a co-payment fee in accordance with my insurance policy and/or my insurer's contract with PFW. I understand that I am also responsible for any deductibles in accordance with my insurance policy and/or my insurer's contract with PFW.

My insurer is _____
Co-payment due $_____
Deductible due $_____
Number of sessions or $ amount allowed annually_____

3. I hereby authorize PFW to release all necessary information to my insurer in order to claim and collect medical insurance payments and benefits on my behalf, including confidential information about my (or my child's) treatment and family history to the extent required by my insurer.

4. I understand if my attorney subpoenas PFW staff to appear in court that I will be billed and agree to pay the $125.00 hourly rate: I understand that this is not a service covered by insurance companies.

5. I understand that I am responsible for informing PFW of any changes in my insurance coverage. I understand that I am responsible for payment for all services provided after my insurance benefits have been exhausted, or if the insurance company denies payment for services that I have received due to circumstances outside of PFW's responsibility.

_____ _____
Client/Guardian Signature Date

☐ Section II: Self-pay Agreement:

I understand that I am not covered by any insurance plan that will compensate for counseling services provided by PFW, or have chosen not to utilize my insurance benefits at this time. I understand that I am personally responsible for paying all fees for services provided by PFW. I have received; reviewed and signed a copy of PFW's Fee Schedule and **agree to pay all fees at the time services are provided**.

_____ _____
Client/Guardian Signature Date

☒ Section III: Appointment Cancellation Agreement:

In the event that I must cancel a scheduled appointment, I agree to give PFW at least 24-hours notice. I understand that if I fail to give 24 hour notice, I will be charged a $25.00 missed appointment fee for which I will be personally responsible.

_____ _____
Client/Guardian Signature Date

☒ Section IV: Non-Payment Agreement:

I have read, and understand, section 14 of Partners in Family Wellness, PLLC's **NOTICE TO CLIENTS AND CONSENT TO TREATMENT AGREEMENT**

_____ _____
Client/Guardian Signature Date

Updated 010211

FEE SCHEDULE
Partners in Family Wellness, PLLC

	FEES
Psychotherapy Services:	
Initial Diagnostic assessment (90791)	$140.00
38-52 min. Individual Psychotherapy (90834)	105.00
53-60 min. Individual Psychotherapy (90837)	135.00
Family Psychotherapy with client (90847)	105.00
Family Psychotherapy without client (90846)	105.00
45-50 min Group Psychotherapy	20.00
Coaching Services:	
Hourly rate	70.00 and up
Telephonic Coaching (Per Hour)	70.00 and up
Consultation Services:	
Hourly rate	75.00
Ancillary Professional Services:	
Court appearances and related services including but not limited to deposition, report writing, travel, and trial preparation (Per Hour)	125.00
Other appearances	75.00
Administrative Services:	
Record copying	2.00/page

DISCOUNTED SELF PAY SCHEDULE						
90791	$70.00	$80.00	$90.00	$100.00	$110.00	$120.00
90834,90846,90847	$50.00	$56.00	$62.00	$68.00	$74.00	$80.00
FAMILY SIZE	**ANNUAL GROSS INCOME BY HOUSEHOLD**					
1	20,000	27,000	34,000	41,000	48,000	55,000
2	27,000	34,000	41,000	48,000	55,000	62,000
3	34,000	41,000	48,000	55,000	62,000	69,000
4	41,000	48,000	55,000	62,000	69,000	76,000
5	48,000	55,000	62,000	69,000	76,000	83,000
6+	55,000	62,000	69,000	76,000	83,000	90,000

*Eligible to uninsured or non-contracted without out-of-network benefits
Requires proof of annual income to qualify(Most recent IRS tax return and recent pay stubs)

Has income been verified? Yes _____ No_____ Signature _____

***PFW reserves the right to change its Fee Schedule and Client Fee Agreement at any time and will advise you of any such changes.**

_____ _____

Client/Guardian Signature **Date**

Updated 010211