

Welcome to CORE Counseling Service. We want you to be aware of the important policies and procedures, which we adhere to at this office.

Please read them and initial to the right of each statement and sign below so that we can be assured you received this information.

1. Confidentiality of client information is observed at CORE. It is our policy not to release any information regarding a client unless we have written permission from you to do so. _____

2. At the initial session we will discuss the frequency of therapy sessions, which will occur weekly, bi-weekly or monthly basis. _____

3. Clients who must **CANCEL** are expected to do so at least **24 hours prior** to their scheduled appointment time. Clients who **fail to CANCEL** within that time frame **WILL BE RESPONSIBLE FOR A FEE OF \$75 for the time reserved.** _____

4. CORE Counseling Service has a fixed cost of therapy, which is \$125 per session. **Time spent over the allotted time will incur an additional cost.** _____

5. If your insurance coverage is an HMO, PPO or Indemnity policy you are responsible for your co-payment, deductible **and any other fees that are not covered in your policy.** **ALL co-pays** are payable the **date of service** by check or cash. _____

6. **Insurance Claims:** We file with most, not all, insurance companies. *All verification of insurance is not a guarantee of payment by the insurance company* therefore; you are responsible for all outstanding balances. We do not bill secondary insurance companies. - _____

7. ATTENTION PARENTS: If you send/drop off your children for therapy they **MUST** have their responsible portion of payment with them. If they do not come with their payment they will not be seen for treatment and you will be billed \$75.00 for that session time. *PARENTS* are responsible for re-scheduling appointments for child/adolescent under 18 years old. _____

8. I understand that I will be charged .02% interest per month on any balance that remains unpaid for more than 60 days after service has been rendered. I also understand that I will be charged and additional \$35 for any checks that may be returned for insufficient funds, closed accounts, etc., in addition to the original amount due. _____

To avoid any misunderstanding, our staff invites early discussion of financial problems or questions regarding fees, payment and insurance
I have read all the information on this form. I agree to all the above policies and procedures.

Client's Signature _____ **Date** _____ 31306