Center for Conscious Counseling

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Payment and Fee Policy

FEES: As of January 1, 2018, these are the current published 50-minute session rates. These rates may increase periodically, and you will be informed prior to any rate changes. Reduced fees are available based on an individual's ability to pay and are determined by mutual agreement. Your signature below indicates your understanding and agreement to these terms.

Service	Provider Level: Psy. D.	Master's Degree
Initial Assessment Appointment	$175.00	$150.00
Individual Psychotherapy	$150.00/hour	$130.00/hour
Couples/Marital/Family Therapy	$170.00/hour	$140.00
Group Psychotherapy	$75.00/ 90-minute session	
Letter and Report Writing	$50.00 PER 15 MIN.	
Representation in Legal Matters	$300.00 PER Hour + Expenses (Portal to Portal)	
No Show/ Cancellation (< 24-hour)	$75	

FEE POLICY AGREEMENT: I understand that payment for professional services is my responsibility. I agree to pay the fee at the time of service unless other arrangements have been made in advance.

I understand that if my clinician is in my network he/she has agreed to the usual and customary rate deemed appropriate by his/her contract with the insurance company. Further, I understand that my clinician may not charge me for the difference between the fees listed above and the agreed upon usual and customary rate, beyond the co-pay required by my insurance.

I understand that my co-pay, co-insurance or private pay fee is _________. I understand that this fee is due at the time of services. If not using insurance for payment, I understand that I am responsible for the full charges of each session at the time of service, unless an alternate arrangement is made with the clinician.

If using insurance for payment, I understand that my insurance company reserves the right to refuse payment for services they previously pre-certified. I understand that in such a case, I have the right to appeal to my insurance company for payment. I understand that I am ultimately responsible for services provided which are not covered by my insurance company. I further understand that by signing this document I am providing Dr. Whetstine and/or his representatives the right to communicate for the purposes of billing the insurance company for services.

No Show/Cancellation: I understand that if I skip or miss a session without at least 24-hours advanced notice to Dr. Whetstine or his representative, I am financially responsible for the missed session as posted above. Waiving this fee is at Dr. Whetstine's or provider's discretion.

Insufficient funds**:** I understand that Dr. Whetstine/CFCC accepts payment by check, cash and credit card and if my personal check is returned for insufficient funds, a $25 fee will be assessed in addition to the appropriate payment for services initially rendered.

Signature of Client or Legal Representative: _____________________________ Date: _______________

Signature of Clinician: ____ Date: _______________