1381 Crossings Centre Drive, Suite E
Forest VA 24551
Phone 434-219-5621 Fax 434-305-1072

CLIENT SERVICES AGREEMENT

1. **FEE SCHEDULE**. Payment for services is required at each session. The fees are as follows:

Intake (First Session)……………………………………………………….$40.00
Therapy Session……………………………………………………………..$40.00 (45-60 minutes)
Extended Therapy Session…………………………………………….$40.00
Phone calls required outside of office hours……………………40.00 per hour
Phone Consultations outside of office hours…………………..$40.00 per hour

-Court appearances and contacts with attorneys follow the fee guidelines established by the Lynchburg Bar Association and the Lynchburg Academy of Medicine. Guidelines are available upon request.
-Insurance reimbursement is the client's responsibility. However, our office will provide assistance with filing claims as needed. Please note: Insurance companies do not reimburse for court appearances, phone consultations, /calls, or missed appointment fees.

2. **COLLECTION OF FEES.** Any expenses incurred in the collection of fees are the sole responsibility of the client. Such expenses may include, but are not limited to, attorneys' fees or collection agency fees. There is a charge of $25.00 for any returned check.
3. **MISSED APPOINTMENTS. There is a charge of $25.00 for any appointment not canceled 24 hours in advance.** To cancel a Monday appointment and avoid this charge, you must call by 5:00pm on the previous Friday. Our office **requires** a credit card to keep on file for the charge of missed appointments.
4. **EMERGENCIES.** In the event of a true emergency after hours, you may call Trish McCoy Kessler , LPC/Owner on her cell phone: (434) 238-5975. Please leave a message. If you do not hear back from her or your therapist within 15 minutes, please contact your family physician, psychiatrist, the Lynchburg General Hospital Emergency Room at (434) 200-3033 or call 911. If she is out of town or otherwise unavailable, emergency coverage will be provided by a licensed colleague acting on her behalf.

I have read the above terms and agree to them.

____ ***If*** using insurance benefits. I also hereby give my permission to release my name, Social Security number, address, and financial information to insurance companies for billing purposes, and to collection agencies, if needed to collet any unpaid bills.

____***If*** self-pay account, I understand that discounted fees are not eligible for submission to any third party payer (i.e. insurance company, public, or private agency/department). I also hereby give my permission to release my name, Social Security Number, address, and financial information to collection agencies, if needed to collect on any unpaid bills.

____________________	x____
Date	*Signature of Client (or Legal Guardian)*
___________________	x____
SSN#	*Signature of Client (if age 14-17)*
	X___________________________________
	Signature of Witness