GCC

Grace Counseling & Consulting, LLC.

Making a lasting difference in the lives of others.

FINANCIAL AGREEMENT

The following document outlines the financial practices of Grace Counseling & Consulting, LLC (GCC) and the financial agreement between GCC and the client.

Individual/Couples Therapy Payment:

All fees are due at the time of the session. Payment can be made through check, credit card or cash. Checks can be made payable to Grace Counseling & Consulting, LLC.

Fees:

60 Minute Initial Session: $200
45 Minute Session: $160
Family/Couple: $200
Group session: $50
Crisis Intervention: $160
60 Minute Consultation: $200

All GCC clients must maintain a valid credit card on file to guarantee their chosen method of payment. For clients paying by check or cash, if payment is not made for two consecutive sessions, then your credit card on file will be charged in the amount of the outstanding balance. If a check is returned for insufficient funds a fee of $25 will be charged.

Insurance

Grace Counseling & Consulting makes every effort to verify your coverage with your insurance. However, you are strongly encouraged to verify your benefits and coverage to ensure you fully understand what is covered. You agree that it is your responsibility to inform the practice of any changes to insurance plan prior to each of your visits, or you may be responsible for the full fee. Some services may not be covered by health insurance. You agree to be fully responsible for payment for all services that are not covered by your health plan. This may include charges for telephone consultations, written correspondence, or reports in connection with a client's evaluation or treatment, including consultation or correspondence with the client, family members, past or current treatment providers, educational professionals, attorneys, courts, agencies, or others. If these charges are excluded from your coverage by your health plan, they will be your responsibility.

Point of Contact

GCC's Dr. Jim Seward, handles all invoicing and payment collection. Clients who have questions about invoicing, payment, or insurance reimbursement can contact him directly at JimS@gcc-cares.org or 515-571-7480.

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Legal Proceedings

If you become involved in legal proceedings that require participation by GCC, you will be expected to pay for all the Therapist's professional time, at their clinical hourly rate, including preparation and transportation costs, even if the Therapist is called to testify by another party. You will also be expected to pay any legal costs incurred by GCC in responding to the legal proceedings.

Release/Duplication of Records

Charges for copying records is billed at the clinical hourly rate.

Client Acknowledgement

I, the client, understand I have the right not to sign this form. I understand I can choose to discuss my concerns with my Therapist. If at any time I have questions about any of the subjects discussed in this form, I can talk with my Therapist about them, and my Therapist will do their best to answer them.

By signing below, I the client, acknowledge that I have read or had read to me the issues and points in this form. I hereby agree to abide by the financial agreement outlined in this form and consent to services provided by GCC clinical staff as shown by my signature below.

Credit Card Authorization

Clients of GCC must maintain a valid credit card on file to guarantee payment.

I _____authorize maintenance of valid credit card information by GCC to guarantee payment. By filling out the information below, I understand that there is a 24-hour cancellation policy and that I will be charged for the session if I am unable to provide 24 hours advance notice of cancellation. I understand that if payment is not made, my credit card on file will be charged in the amount of the outstanding balance.

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Credit Card Authorization

Card Type: Visa MasterCard Discover Other _____

Cardholder Name:

_____

Billing Address: _____ City _____ State _____ Zip_____

Credit Card Number:

_____

Expiration Date: _____

3 Digit CVV Code: _____

Email Address: _____

Phone: _____

Cardholder/Client Signature _____

Date: _____

By signing below, I acknowledge that I understand the above information. I also AUTHORIZE THE RELEASE OF INFORMATION necessary to process my insurance/ EAP/ managed care/ DDS claim and I ACKNOWLEDGE FINANCIAL RESPONSIBILITY for this account.

CLIENT SIGNATURE _____ DATE_____

AUTHORIZED SIGNATURE FOR A MINOR _____ DATE_____