**Annemarie Husser LCPC, LLC**

**455 Coventry Lane, Suite 105**

**Crystal Lake, IL 60014**

**779-704-0931**

**Financial Agreement**

**Payment**

**\_\_\_\_\_You will be required to pay** **for each session at the time it is held**, unless we agree otherwise or you have insurance coverage which requires another agreement**. You will always be expected to pay the insurance co-pay, co-insurance or deductible amounts at the time of service.** **If your deductible has not been met, a payment is expected at the time of service.** Payment may be in the form of check, cash, or credit card. My rate is $175.00 for an initial Diagnostic Assessment, $150.00 for a 60 minute session, $130.00 for a 45 minute session and $100.00 for a 30 minute session. Contacting Annemarie Husser LCPC by phone to discuss matters besides an appointment reschedule will result in a session charge that cannot be billed by insurance. Annemarie Husser LCPC only responds to email and text messages for rescheduling purposes. The returned check fee is $100.00. **Any work outside scheduled sessions is fee-based.**

**Appointments**

**\_\_\_\_\_**If I am unable to keep an appointment, I will provide notification as soon as possible. If an appointment is canceled or missed without 24 hours’ notice, I understand that I will be billed at a late cancellation fee of $50.00 to cover loss of income. **Mental health emergencies are not managed in this out-patient office. You are to call 911 or go to your nearest hospital emergency room for services.**

**Insurance**

**\_\_\_\_\_**I understand that you may provide me with a receipt which I can use to file my insurance if Annemarie Husser LCPC is not a participating provider on my insurance plan. You may provide a service for me by filing insurance on my behalf if Annemarie Husser LCPC is a participating provider on my insurance plan. When you provide this service, I authorize you to release medical or other necessary information to process the claim and I authorize payment to Annemarie Husser LCPC. I understand that Annemarie Husser LCPC will be submitting a clinical diagnosis for the person identified as the client on the insurance claim form in order to receive reimbursement. **In the event that my insurance will not pay for any services provided, I understand that I am responsible for the full payment.**

**Privacy Notice**

**Your signature affirms that you have received the *Notice of Clinician’s Policies and Practices to Protect the Privacy of Your Health Information.***

**I understand that Annemarie Husser LCPC does not testify in court cases unless directed by a court order. I have read, initialed the statements and understand the above statements:**

**Signature of client/guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**