Serenity in Motion
Counseling Services

Client Financial Agreement:

First Name	Middle Name	Last Name	
SS#	DOB	Gender	
Physical Address	City	State	Zip Code
Mailing Address	City	State	Zip Code
Employer Name	Employer Address	Occupation	
Home Phone	Work Phone	Cell Phone	
Email Address	Emergency Contact Name	Emergency Contact Number	

In agreement with the services that will be provided by Serenity in Motion, I hereby agree and authorize my insurance company to pay this practice in full for services rendered in accordance with my medical benefits, as agreed to in my insurance policy. I hereby authorize Serenity in Motion to release to my insurance company any information necessary for seeking reimbursement for the services listed below.

FEE SCHEDULE:

Initial Therapy Evaluation (60 minutes)	$200
Chemical Dependency Evaluation (60 minutes)	$200
Individual, Couples, Family Therapy Session (55 minutes)	$150
Group Therapy Session (60-90 minutes)	$70-$105
Court Appearance Retainer (minimum 3 hours)	$450
Court Appearance Fee/Depositions per hour	$150
Phone Consultation, Report Writing, Professional Fees per hour	$150

CO-PAYMENTS:

All applicable co-payments, deductibles, or any other out-of-pocket expenses are expected to be paid at the time of the appointment. The co-payment/co-insurance/deductible is your responsibility and payments are expected at the time of your appointment unless your insurance coverage requires another arrangement. Payment is accepted by cash, check, credit card, or debit card. A $50 fee will be charged for checks returned due to insufficient funds, which is due at the time of the next session. Serenity in Motion reserves the right to increase fees in the future to a reasonable amount, and you will be given adequate advanced notice if this should occur.

My insurance provider is_____.
My co-payment (as assigned by my insurance company) is $_____.
My insurance entitles me to _____ therapy sessions per year, of which I have used _____.

501 East Front Street, Suite 513, Butte, MT 59701
406.565.5154 ph 406.565.5040 fax
www.serenityinmotion.org

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MISSED APPOINTMENTS:
I understand that it is my responsibility to schedule and ensure that these appointments are kept. I understand that if I am unable to attend my scheduled appointment that I must call, cancel, or reschedule my appointment at least 24 hours before the appointment.

COLLECTIONS:
Bills that are over 90 days overdue may be forwarded for collections. Insurance claims not paid within 90 days may be billed to you. You are responsible for any fees incurred by Serenity in Motion during the attempt to collect overdue payments, including attorney fees.

INSURANCE PROCESSING:
Your insurance company may require that you pre-authorize your treatment with us prior to your visit. It is your responsibility to monitor insurance benefits, co-payments, deductibles, as well as effective and termination dates of coverage. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have any questions, please contact your plan administrator. Feel free to speak with your provider if assistance is needed with this.

Our financial agreement with you is one aspect of our therapeutic relationship. You have our commitment to your healing and well-being, and this includes our willingness to form a financial contract with you that will be mutually agreeable. By signing below, you affirm that you have read, understand, and agree to the finance agreement as outlined above.

I authorize my insurance company to make payments directly to Serenity in Motion for services rendered.

Client Printed Name (or parent/guardian if client under age 18) mm/dd/yyyy

Client Signature (or parent/guardian if client under age 18) mm/dd/yyyy

Serenity in Motion, LLC Representative Signature mm/dd/yyyy

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