LAKE COOK BEHAVIORAL HEALTH

PAYMENT AGREEMENT

This agreement is for the client portion of the bill for services rendered. Clients are responsible for the payment of any copay, coinsurance and/or unmet deductible, payable at the time of service. To insure your account is kept up to date, we will keep a credit card on file to process payments at time of service. Check and Cash payments are also accepted, but does not eliminate the requirement that a card be kept on file.

****Appointments must be cancelled 24 hours prior to the scheduled appointment time. There will be a charge of $125 for an appointment not cancelled with at least 24 hours notice.**

*****Group sessions must be canceled 24 hours prior to their scheduled time. There will be a charge of $40 for an appointment not cancelled with at least 24 hours notice.**

FEES FOR NON-COUNSELING SERVICES

Services not covered by insurance will be charged at the following rates:

Reports $175.00 an hour for most administrative, letter writing, report writing activities, etc. which can be prorated to a minimum of 15 minutes ($43.75).

Record Copying $25.00 for copying medical records of up to 50 pages. Beyond 50 pages, a fee of $0.25 per page and $35.00an hour, as well as postage fees will be charged to the client.

Out of Office Activities Including but not limited to educational meetings, clinical staffing, court appearances, etc. are billed at $175.00 per hour including preparation time, which can be prorated.

Travel Time Travel time to and from any such event is billed at $87.50 an hour, which can be prorated.

Phone Calls Any phone call under 10 minutes will not result in a service fee. Charges for calls lasting longer than 10 minutes will be billed at $125.00 an hour, which can be prorated. This does not apply to calls made for consultation with other healthcare professionals for routine clinical purposes.

I, the undersigned, authorize Lake Cook Behavioral Health to keep my debit/credit card on file for fees related to services rendered.

I understand that I am financially responsible to Lake Cook Behavioral Health for charges not covered by insurance.

I understand that a No Show or Late Cancellation fees will be charged to my debit/credit card on the day that service was to be performed.

I understand that this form is valid unless I cancel such Agreement through written notice to Lake Cook Behavioral Health.

Signature _____ Date _____

Submit Cancel