

Financial Policy

Fees and Payment Options

My fee per session varies depending on the services needed and has been established with you during intake. Payment is due in full at the time of service. I accept cash, check, debit cards, credit cards. If paying in cash, please bring the exact amount due for your session. I am unable to provide change, so any extra payments will be credited to your account. If you are overdue on your payments, I will assess a fee of 10% on your total balance. There is a \$30 service charge for all returned checks.

Case management is billed in increments of 15 minutes, so any phone calls, document reviews or consultations over 15 minutes will be billed at \$30 per 15 minutes. Court testimony (including preparation, travel, wait time and testimony) and document preparation/letter writing are billed at \$275 per hour. I require an up-front retainer based on estimation of how many hours will be needed. You may pay directly or have your attorney pay the retainer.

Please give at least 24 hours notice when cancelling an appointment. Appointments not cancelled 24 hours in advance will be charged to your account. Exceptions may be made for emergency situations based on therapist discrepancy.

FEES AND SERVICES	AMOUNT
INDIVIDUAL, CHILD THERAPY	\$95 PER HOUR
CASE MANAGEMENT (I.E., PHONE CALLS, CONSULTATIONS, MEETINGS)	\$50-\$150 PER HOUR
COURT TESTIMONY/DOCUMENTATION (INCLUDING TRAVEL AND WAIT TIME)	\$275 PER HOUR (RETAINER REQUIRED)
LATE CANCELLATIONS/MISSED APPOINTMENTS	\$95
RETURNED CHECKS	\$30 PER CHECK
OVERDUE PAYMENTS FEE	10% OF TOTAL DUE

Sliding-Scale Fees

I accept a limited number of sliding-scale fee clients, which are typically long-term clients who have exhausted all other payment methods. Out of courtesy, I ask that all sliding-scale clients are particularly careful to pay their fees in a timely fashion and are sure to regularly attend all of their sessions.

Insurance

At the present time I do not take insurance and in the future, I will not directly bill insurance, however, I can provide you with an invoice that you can submit to your health insurance plan for reimbursement at a later date. Please be advised that most insurance companies require submission of statements within 90-180 days of treatment to qualify for reimbursement. In addition, I am required to provide a diagnosis to your insurance company. If you are concerned about having a mental health diagnosis in your medical record, please notify me and we can discuss your options.

Credit/Debit Authorization:

I hereby authorize Alison Biggs, MA, LPCC, NCC to keep my signature on file and charge my credit/debit card selected below for the following: All charges incurred at the time of service (therapy

sessions, court preparation and attendance, document preparation, etc.), including no shows and sessions cancelled without 24 hours notice.

Mark One: Visa MasterCard American Express Discover Other

Mark One: Credit Debit

Cardholder's Name (as it appears on your card): -

Card Number: _____/_____/_____/_____/_____

Expiration Date: _____/_____ CSC (3 digit code on back of card): _____

Billing Address: _____ Apt. # _____

City/State: _____ Zip: _____

I understand this form is valid unless I cancel this authorization through written notice to Alison A. Biggs, MA, LPCC, NCC.

Please be aware that any account 90 days past due will be turned over to a collection agency. At that time, information including your name, address, telephone, date of birth and other identifying information will be supplied to the collection agency.

Agreement

I have read and understand this financial policy and agree to the above stated fees and procedures.

Client Name (please print)
Date

Client Signature (if necessary)

Parent/Guardian Name
Date

Parent/Guardian Signature

Alison Biggs, MA, LPCC, NCC

Therapist Name
Date

Therapist Signature