**FEE AND BILLING AGREEMENT**

**CLIENT INFORMATION**

Name: Date of Birth:

Gender: Age:

Address: City, State, Zip:

Telephone: Email:

May I leave a message on any of the telephones listed above?

**FEES**

86-min Intake Session 200.00

55-min Individual Session 200.00

55-min Family Session 200.00

Less than 24-hour Notice Cancellation Fee 100.00

I accept cash or checks payable to Ronnie Hansen, LCSW. Please plan to have your payment ready at the beginning of each session. I am able to bill your primary and some secondary insurances. You will be responsible for any copay and deductible at the beginning of each session. I may have a different financial agreement with your insurance company or Employee Assistance Program (EAP). Sliding scale fees are available upon request. Three no-show or late cancellation occurrences is grounds for termination from counseling except in extreme cases. I value, and protect, the time scheduled for us. Please call as soon as you are aware of the need to arrive late or cancel a session so I can plan accordingly.

**DELINQUENT ACCOUNTS**

Balances left unpaid after 90-days from the date of services will be assessed a 1.5% rebilling fee (minimum $5) per month. If an account is seriously delinquent, I will provide 30-day notice prior to referring the matter to a collection agency to facilitate payment. If missed appointments are a recurrent problem, I may ask for a retainer before scheduling the next appointment.

**OFFICE HOURS**

My office hours are typically Monday through Thursday 9:00-3:00. To reach me during those hours, please call 929.515.4102 and I will return your call as soon as I am able. I am committed to returning voicemails within my following business day. In case of emergency, please call 911 or go to your nearest emergency room. Benton County’s 24-hour crisis line can be reached at 1-888-232-7192.

**CONFIDENTIALLITY**

Your participation in treatment and all related information is confidential and will not be disclosed without your consent. Exceptions to this are outlined in my Notice of Privacy Practices.

**INSURANCE INFORMATION**

Please provide a copy of the front and back of insurance cards. If you are using health insurance benefits, you are responsible for being aware of your policy’s benefits and limitations. Insurance payments will be applied to your balance. Any positive balances are applied to future co-payments or refunded.

Primary Insurance: Phone:

Claims Address: City, State, Zip:

ID Number: Group Number:

Name of Insured: Relationship to Client:

Insured’s DOB: Insured’s Phone:

Insured’s Address: City, State, Zip:

Insured’s Employer:

Secondary Insurance: Phone:

Claims Address: City, State, Zip:

ID Number: Group Number:

Name of Insured: Relationship to Client:

Insured’s DOB: Insured’s Phone:

Insured’s Address: City, State, Zip:

Insured’s Employer:

* I hereby authorize the release of all health care information necessary to process an insurance claim.
* I hereby authorize my insurance carrier to make payments directly to Ronnie Hansen, LCSW.
* I understand I am financially responsible for all charges regardless of insurance, unless otherwise written by Ronnie Hansen, LCSW.
* I understand the financial policies established by Ronnie Hansen, LCSW.

Client Signature: Date:

Insured/Authorized Signature: Date: