

Guiding Empathy Inc.

7755 Center Avenue, Ste 1100, Office 1118
Huntington Beach, CA 92647

Financial Agreement

Sessions, Fees, and Payment

Each therapy session lasts approximately 45 minutes (This is the allotted time that most insurance plans cover.) Typically, sessions take place on a weekly basis at a mutually agreed date and time.

45-minute individual session with Therapist	\$120
60-minute individual session	\$135
<i>The above are private pay rates- using insurance plan will be less.</i>	
45-minute couple's therapy session	\$130
60-minute couple's therapy session	\$145
<i>The above are private pay rates- using insurance plan will be less.</i>	
Written reports and/or letters	\$65
Fee for Copying Records	\$20 +15 cents per copy
Professional consultation (responding to subpoenas, Doctor, Lawyer, School Counselor)	\$125 per hour
No-Show or Late Cancellation Fee	\$65

Certain insurance plans have pre-determined fee arrangements that may differ from the amounts mentioned above. Upon verification of your eligibility and benefits, your insurance carrier will be billed for you and your therapist will be paid directly by the carrier. You are responsible for any applicable deductibles, co-payments, co-insurance, or session fees if you are not eligible for services by your insurance carrier. We may provide you with a superbill, upon request; however, we cannot guarantee that your insurance plan will reimburse you for the session.

All fees are to be paid at the time of service. We offer a sliding scale on a case-by-case basis. If you feel that a reduction is warranted for you, please ask your therapist.

After claims process, any unpaid client balance will be charged to the card on file. All remaining balance are due upon receipt, unless other payment arrangements are made.

Please be aware that if you are being seen with your out-of-network benefits, some insurance carriers may send you the session payment directly. This payment is to be forwarded to Guiding Empathy Inc. for payment of services rendered.

It is the responsibility of the insured/parent/client to present secondary or tertiary coverage at the time of initial visit. If not presented at the initial visit, the client/parent will be responsible for filing secondary claims themselves. The client/parent is also responsible for keeping track of referrals, authorizations and/or plan limitations including visit limitation. Any information or statements

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written here are not a guarantee to make benefits and/or payment and are subject to payment of premiums, as well as, policy limitations and exclusions outlines in your plan guidelines.

The information above including your insurance network status was obtained based on the questions asked of your Insurance Carrier when checking benefits. Network status is based on information given to the Practice by your insurance carrier when verifying benefits. We recommend checking with your insurance directly to obtain network status. No insurance carrier will guarantee benefits until a claim is received in their office and reviewed for medical necessity. Please note any insurance carrier has the right to deny any type of claim including therapy, other services, or supplies for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

No-Show and Cancellation

We require that you cancel 24 hours prior to your scheduled session and notify your therapist directly via their personal, confidential telephone. If you do not attend a scheduled session or cancel late, we cannot use this time for another client. You are responsible for the entire cost of the session, including co-payment amount, with less than a 24-hour notice. This charge cannot be billed to your insurance plan. Payment will be charged to the card on file or will be collected via telephone or electronically. Payment for no-show or late cancellation is due prior to scheduling another session.

Your therapist and our office operate on different schedules; therefore, we cannot guarantee that your message will be delivered to your therapist in a timely manner. Please contact your therapist directly for all communication, scheduling, and cancellation. If you lose your therapist's contact information, you may contact our office for their information. If you need to contact our office for your therapist's information, we advise that you plan accordingly so that you may relay your scheduling issues with your therapist in a timely manner.

CalOptima Clients

CalOptima clients are responsible for checking their eligibility status on a monthly basis. Making sure you're eligible to receive mental health services will reduce your financial responsibility associated with your plan inactivity. If your plan becomes inactive while receiving services, please speak with your local social services agency at (800)281-9799 in an attempt to reestablish your benefit eligibility. If you are unable to reestablish your eligibility with CalOptima, the balances left unpaid will be due by you. If you are unable to pay this balance, please contact Billing to set up an agreed-upon payment schedule. If your balance remains unpaid, then your account will become delinquent. For additional information, please see the delinquent accounts section.

Delinquent Accounts

Any unpaid balances past 30 days will result in a delinquent account. Guiding Empathy Inc. will begin collection procedures. We will attempt to contact you directly. If your account remains delinquent past 90 days, an outside collection agency may be used. In such cases, non-clinical information (as given on the New Client Information form) may be released to assist in the collection of the amount due.

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CalOptima Clients:
I authorize Guiding Empathy Inc. to bill my CalOptima insurance plan to obtain reimbursement.

Private Insurance Clients:
I authorize Guiding Empathy Inc. to bill my private insurance with: _____
I am responsible for a \$_____ co-payment or a _____% coinsurance each session associated with the insurance above.

Cash Pay Clients:
I agree that I am responsible for the payment of \$_____ per session (45-minutes), which is due and payable at the time of the session.

Please check one: Accept a copy of Agreement Decline a copy of Agreement

Private Insurance Clients Only Credit Card Authorization

All private insurance clients are required to keep a valid credit card on file. For your convenience, this credit card will only be used as a form of payment for fees incurred for deductibles, co-payments, co-insurance, no-show or late cancellations, or returned checks.

Card Type: Visa Mastercard Discover American Express

Card Number: _____ Exp. Date: _____ CSC Code: _____

Name as Printed on Card: _____

Billing Address: _____
(Number and Street) (City) (State, Zip)

I agree that all the information provided is accurate and complete. With my signature, I certify that I am an authorized signer on the above credit card account. I authorize Guiding Empathy Inc. to make charges to my credit card for services rendered according to the terms specified in this Contract.

Authorized Cardholder Signature

Date

Print Client Name

Signature of Person Financially Responsible

Date

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