

# Harvest Counseling

Glen Keefe MA, LMHC

## Patient Financial Policy

Patient's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### **Payment:**

The cost of counseling with Harvest Counseling is \$200.00 for the initial evaluation (60 minutes). Subsequent sessions are billed at \$155.00.

Insurance companies will not allow 90-minute sessions except for when medically necessary. If you would prefer to meet with your therapist for 90 minutes, then you may pay \$80.00 for the additional 30 minutes. Please note that you will be required to pay your co-pay for the first hour, as well as the additional \$80.00.

You are required to present a valid insurance card and driver's license as needed throughout your care.

Commercial Insurance Carriers: I bill most insurance carriers for you if proper paperwork is provided. Any outstanding balances, co-payments and deductibles are due prior to your appointment. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full by you.

Medicare and Medicaid: We do not contract with or accept Medicare or Medicaid.

### **Methods of Payment:**

Cash, Personal Checks, Debit and Credit Cards. We request that a credit card be kept on file for your convenience and ours.

My billing is provided by Northwest Clinical Billing, LLC. You can reach David Longmuir at 1-360-768-2168. David can help you obtain this information from your health insurance plan; however you are responsible for understanding your health insurance plan benefits. David can also help with questions about payments or the balance of your bill and receiving payments.

### **Cancellation:**

**Twenty-four hour notice of cancellation is required. In general, it is not possible to fill a time slot on short notice that your therapist has reserved for a client. It is, therefore, the policy of this office to charge 125.00 for a missed appointment or short notice cancellation.**

***I understand that I am ultimately responsible for all fees for services. I have read, understood and agree to the above financial policy for payments of professional fees.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_