Family Counseling Center, Inc.
Agreement to Pay for Professional Services

When you make an individual appointment with the counselor, that time is reserved for you alone. We never "double book". If you do not keep that appointment, there is no way that time can be utilized by another client. THEREFORE, any time you make an individual appointment and you do not provide proper notice of cancellation (24 hours), you will be charged a $ 50 missed appointment fee. If you are utilizing you health insurance benefits, you should know that your insurance company is unlikely to pay for an improperly noticed cancellation or "no show" appointment and you will be responsible for the bill.

Employee Assistance Program (EAP) sessions are a benefit provided by your employer with no out-of-pocket expense to you. However, if you fail to provide proper notice of cancellation (24 hours), you will be charged a $ 50 missed appointment fee for that appointment. You should know that your EAP provider is unlikely to pay for an improperly noticed cancellation or "no show" appointment and you will be responsible for the bill.

EAP Confidentiality

- If you were referred directly by your employer (**mandatory referral**), usually as part of a disciplinary action, you will have signed a confidentiality release and we will be providing your employer feedback about your attendance and progress.
- However, if you contacted EAP on your own, no identifiable information will be provided to your employer. Only demographic/statistical information, for example number of clients served, will be reported to your employer.

Early Morning and Evening Appointments: For the convenience of clients and to reduce disruption to home and work schedules, we will on a case by case basis arrange appointments outside the business day (9 am to 5 pm). However, any client who schedules an appointment outside the business day and then does not keep that appointment and who has failed to provide proper notice (24 hours), may not be scheduled outside the business day for subsequent appointments.

I understand that fees for missed or cancelled appointments without proper notice (24 hours notice) will be my responsibility and will be billed a $ 50 missed appointment fee. The Family Counseling Center charges a $ 25 returned check fee for checks returned for insufficient funds.

Further, I understand that insurance deductibles, co-payments, or "full-fee for services" are due at the time of service. While I am authorizing Family Counseling Center, Inc. to attempt to access my insurance benefits (if any) to cover fees in-part or in-full, I understand that I am personally responsible for all charges/fees should my insurance provider not cover services.

I authorize the Family Counseling Center, Inc. to release any or all clinical and/or therapeutic information to my insurance provider for the purpose of securing payment and/or to be made public if required to seek legal remedies for non-payment.

I understand my rights as a client and my responsibilities for payment.

I understand that failure to fulfill my financial obligation is a treatment issue.

Client Name (print): _____

Client Signature (sign): _____ date: _____

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