**FEE AGREEMENT**

I understand that I ,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am responsible for payment of session fees at the time of service to

*Patricia M. Wilkins-Vacca, LCSW, PC*

I understand that I am responsible for

- a $30.00 fee for any returned check.

- Full session fee will be applied for missed/cancelled sessions if I do not cancel at least 24 hours prior to my scheduled appointment or if I do not show for my appointment.

I am notresponsible for any session fees when the session is cancelled by the therapist.

Session fees may be paid in cash or via credit card. I understand that once my credit card is put on file, the card will be charged just prior to each session and will be charged if I no show or late cancel. I will update my card as needed. I will let my therapist know ahead of time if I wish to pay via a different method.

The following are the fees for treatment services:

Intake – 60 min $170

Individual – 45 min $135

Family- 45 min $135

Parent guidance- 45 min $135

Group- 45 min $TBD

Group- 30 min $TBD

Child in school Observation - 60 min $150

Attendance in collaborative meetings $150

Home Visit 60 min $160 $70 for each additional 30 min.

Fee to appear in court $1,500

\*Fees may be changed at the therapist’s discretion. Any change to the client’s fee will be discussed with the client prior to change and noted above on this agreement..

\*In School Sessions and Observations Fees are the responsibility of the parent/guardian and must be paid prior to the scheduled session.
All fees and services are discussed prior to session in addition to this fee agreement. I will also provide you with a GFE: Good Faith Estimate at your request.

Please note that some services are not covered by insurance plans.

**Utilizing Insurance Benefits**

I understand that any reimbursement by my insurance company, and any benefits, are between me and my insurance company, my therapist will not get involved in any way. My therapist will provide me with necessary documentation to submit to my insurance for reimbursement; any denial or expectation of reimbursement needs to be discussed with my insurance company. If my therapist is a contracted provider with my insurance company, my therapist will submit and bill for services; any denials of coverage will be my responsibility to pay in full, and my co pay will be noted here.

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Client/Parent/Guardian Signature Date

Witness/Therapist