BROWNSBURG GUIDANCE
&
COUNSELING CENTER

1103 E. Main St.
Brownsburg, IN 46112
Phone: (317) 852-6603
Fax: (317) 350-2939

Client Fee Agreement

1. The basic fee for service is $125 per hour for all clients. The initial (intake) session is $135. The exceptions to these rates are services covered at a **"contracted rate"** as agreed upon with your insurance plan as an **"in network"** provider.

2. Clients who can not afford to pay the full fee of $125 per hour may qualify for our sliding fee scale. In order to be eligible for the sliding fee scale, your annual gross income must qualify, our services are not covered by your insurance plan, or you have no insurance coverage and will be paying privately. The sliding fee scale ranges from $65 to $125 per session.

    a. For example: If the sliding fee scale rate is $80 per hour, that amount is deducted from the $125 per hour full fee for the service and $45 is written off.

2. If services are covered under your insurance plan on an **"out of network"** (**non-contracted)** basis, and your yearly deductible has not been met, you may be eligible for the sliding fee scale. Once your deductible has been met, you will no longer be eligible for the sliding fee scale and must pay a co-pay. Your insurance will be billed at the $125 per hour rate ($135 for the initial session) for services rendered. The co-pay amount will be determined by taking into account your insurance plan's benefits, income level, number of dependents, and over all financial situation. The portion of the $125 per hour fee not covered by the insurance plan's payment and co-pay amount will be "written off".

    a. For example: If the insurance plan is billed at a rate of $125 per hour and the client pays a $40 co-pay. This leaves a balance of $85. The insurance plan pays only $65 for the session. The unpaid balance of $20 is written off.

4. All clients with an insurance plan covering our services and having met their deductible will be responsible for paying the **"in-network"** co-pay amount required by their plan, **or** if **"out of network"**, the copay amount determined by your therapist.

5. Insured clients signing this agreement understand they are giving consent for all insurance payments for services rendered to be sent directly to Brownsburg Guidance & Counseling Center and your provider/therapist. Furthermore, you are authorizing us to release any clinical information necessary to the insurance company for processing claims and obtaining reimbursement. We will submit your insurance claim. If the insurance company sends the payment directly to you, you agree to endorse the check and forward it and EOB to your provider/therapist at Brownsburg Guidance & Counseling Center.

6. For missed or canceled appointments without 24 hours notice given, you will be billed at the minimum sliding fee scale rate of $65 per hour. There is no charge for missed appointments due to the following: medical or weather emergency, death in the family, employer requirement to work, or other condition beyond your control. Your therapist may waive the charge at their discretion upon evaluating the circumstances.

7. All fees are to be paid at the conclusion of your session unless other arrangements for payment have been made prior to that appointment. There is a $25 charge for any returned NSF or ISF checks. ***Clients are to pay all attorney fees, court costs, and other associated collection expenses, if non-compliant with the terms of this agreement.***

I or (We) hereby agree to the terms and conditions stated in the "Client Fee Agreement":

Client Name _____ (Print)

Client Signature _____ Date: _____

Client Name _____ (Print)

Client Signature _____ Date: _____

Parent Name/Guardian _____ (Print)

Parent/Guardian Signature _____ Date: _____

Witness Name _____ (Print)

Witness Signature _____ Date: _____

Sliding Fee Scale Rate: _____

Insurance Co-Pay: _____