Lupine Counseling

Mychelle Moritz, LPC, ATR-BC
Trauma Processing, Counseling, and Art Therapy

www.lupinecounseling.com

Counseling Fee Agreement

Name: ____

Billing Address: ____

____

I agree to the following fee structure per session for counseling or art therapy services:

___ Insurance with a Co-Pay: $_________________

Deductible: $________________

____ $110 per Counseling Session

____ $ _______ per Other Session

____ $ _______ per Sliding Scale Session

My Household income is $_____________ with __________ household members.

Here are the circumstances that indicate a need for sliding scale. I understand that sliding scale appointments are of limited availability.
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____

Insurance or EAP Information

Health Plan (Primary) ____
Subscriber Name ____
Relationship to Subscriber ____
ID # ____
Group Policy # ____
Employer (for Group or Plan) ____
Check if you are using your EAP (Employee Assistance Program) [ ]

Health Plan (Secondary) ____
Subscriber Name ____
Relationship to Subscriber ____
ID # ____
Group Policy # ____
Employer (for Group or Plan) ____
Type of Additional Coverage: Secondary [ ] or EAP [ ]

I agree to authorize Mychelle Moritz and Lupine Counseling, LLC to hold my credit card information on file and charge per session, unless I pay by check, charge per no show, charge per last minute cancellation with less than 24-hour notice, and charge for other fees outlined in the informed consent form.

Credit Card # ____ Expiration Date ________________

3 Digit Code # _________________________

This agreement pertains to services beginning on _________________ (date) and will remain in effect until a new written agreement is made. I agree to make payments at the time that services are rendered. If insurance is chosen above, I authorize Lupine Counseling, LLC or Mychelle Moritz to bill my insurance for services rendered. I understand that I am responsible for full session fees until my insurance deductible is met. I understand and agree that I am responsible for updating my information when needed. I also understand and agree that a late cancelation or no show will result in a full session fee (copay plus the remainder of the session fee) to my credit card without further notification. I understand and agree that any outstanding balances not covered by my insurance or any balances resulting from failure to update insurance information will also be charged to my credit card, and I will be notified two business days prior to this charge.

Client Signature ____ Date __________________

Client Name (print) ____

Provider Signature ____ Date __________________

Provider Name (print) ____