

Creating Connections Counseling, PLLC

Payment Policies

Patient: _____ Child Self

Responsible Party: _____

Please make sure you understand the following information from your insurance provider.

- ❖ Creating Counseling Connections is an **in-network** provider with your insurance company.
- ❖ Mental health benefits for family and individual outpatient therapy billed as an office visit is covered by your insurance company.
- ❖ That the credentials LISW are reimbursed by your insurance company
- ❖ That you are aware if there is a limited number of sessions covered per year.
- ❖ The amount of your co-pay for office visit or co-insurance rate.
- ❖ The amount of your deductible for the year and what is remaining, whether mental health office visits are applied to the deductible.

Fees for Therapy Services

❖ Diagnostic Interview	90791	\$185.00
❖ Individual Therapy, 30 minutes	90832	\$75.00
❖ Individual Therapy, 45 minutes	90834	\$100.00
❖ Individual Therapy, 60 minutes	90837	\$150.00
❖ Family Therapy	90847	\$125.00
❖ Testing and Assessment	96101	\$110.00
❖ Report Writing	unbillable	\$45.00 per hour of preparation
❖ Specialized Attachment Evaluation w/ full report and recommendations	unbillable	\$1500.00

Please sign below if you are paying for services through your insurance carrier:

- ✓ I have mental health coverage through my insurance company and authorize billing and payment to Creating Connections Counseling for services rendered.
- ✓ I agree to immediately notify CCC of any changes to my policy, including cancellation of policy, new policy, changes in benefits, and changes to secondary insurance. Failure to do so means I assume responsibility for the fees for services rendered as outlined above.
- ✓ I understand that if my insurance policy denies payment for any reason, that I will be responsible for the allowed payable amount by the insurance company or the full amount of the private pay policy as determined by the balance of the account.
- ✓ I am aware of my deductible amount, and agree to pay the allowable amount by the insurance company until my deductible is met and assigned benefits begin.
- ✓ I understand that my co-pay/co-insurance rate is _____ and is payable at each visit.

Signature of Responsible Party: _____ Date: _____

Creating Connections Counseling, PLLC

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Patient: _____ Child _____ Self _____

Responsible Party: _____

Please sign below if you are planning to private pay for mental health services

- ✓ I agree to personally pay for services itemized above at each session for each service rendered.
- ✓ I understand that should I decide to start utilizing my insurance policy, that no previous dates of service can be billed to insurance.
- ✓ I agree to provide payment at the time of service
- ✓ I understand that my therapist has the right to suspend further sessions until the outstanding balance is paid in full.

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