

Lisa Dumain, MSW, LCSW

Fee Agreement

MEETINGS

My session time will usually be 50 minutes per week at a time we agree upon, although some sessions may be longer/shorter or more/less frequent.

Once an appointment time is scheduled, you will be expected to attend unless you provide **24-hour** advance notice of cancellation. This cancellation requires confirmation from me. I highly recommend contacting me directly by telephone.

The expectation of payment for missed appointments without advance notice is \$55.00.

If more than two sessions are cancelled/missed with less than 24 hours' notice, I may suggest different treatment options/locations which might better fit your needs. If you are more than 15 minutes late for a session without mutual agreement, I reserve the right to cancel the session and consider it a missed appointment.

PROFESSIONAL FEES

My current rates are as follows:

- * 75 minutes Individual or Family Initial Visit: \$130
- *45-50 minutes Individual or Family Follow-up Visit: \$95
- *55+ minutes Individual or Family Follow-up Visit: \$115
- *Group Session (when available): \$40
- *Telephone Calls (in excess of 10 minutes): \$50/hour
- *Letter Writing/Clinical Summaries: \$50/hour

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$150.00 per hour for preparation and attendance at any legal proceeding, regardless of whether I am called to testify. This rate applies, but is not limited to preparation, travel, time spent in courtroom, time testifying, time preparing documents for production, and telephone calls related to the legal proceeding.

BILLING AND PAYMENTS

You will be expected to pay for each session with **cash or check** at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Should any checks be returned for insufficient funds, you will be responsible for covering any bank fees in addition to the original check amount. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan. I am happy to provide you with a monthly invoice/receipt for your records and/or submission for any kind of reimbursement account.

If your account has not been paid for more than 4 sessions and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, these costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for behavioral health services. I will submit all claims electronically if you are covered by Blue Cross Blue Shield plans for which I am an in-network provider. For all others, I will provide the necessary forms for you to file with your insurance company for out-of-network reimbursement, if desired. Payment is expected at time of service if using out-of-network benefits. You, not your insurance company, are responsible for full payment of my fees.

You should carefully read the section in your insurance coverage booklet that describes behavioral health services. If you have questions about the coverage, call your plan administrator.

It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your therapeutic work.

Your signature below indicates that you have read the information in this fee agreement and agree to abide by its terms during our professional relationship.

Signature of Person Receiving Services: _____ Date: _____

Signature of Legal Guardian (if required): _____ Date: _____

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