

FEE AGREEMENT

My signature below means I understand my fee is _____ which I agree to pay in cash or by check at each therapy session. It also means I have been told how this fee is determined and I have received clear answers to any questions I have asked. My signature also means I am responsible for paying the full, negotiated fee for any appointment I schedule but do not show for (i.e., a "no show") or fail to cancel at least 24 hours before the scheduled appointment (i.e., a "late cancel"). My signature also acknowledges that I know that if someone else is responsible for payment of my therapy fees that Jim Wayland, Ph.D., LPC, LCDC may contact the responsible party listed above concerning billing or overdue balances.

Signature: _____ Date: _____

PLEASE READ AND FILL OUT THIS SECTION IF YOU WILL BE FILING INSURANCE

Important information about filing insurance for mental health treatment

Your insurance company may handle mental health benefits differently than medical benefits. I strongly recommend you call your insurance company to ask questions about mental health benefits before you decide to use insurance for psychotherapy. Many insurance plans will only pay for individual psychotherapy, not couple's or family therapy. If you are seeing me in a couple or a family I will not tell the insurance company I am doing individual therapy. As a result, you may be refused reimbursement for treatment. Most insurance companies require a mental illness diagnosis be made in order to receive payment for therapy. I will not make a mental illness diagnosis unless I believe it is warranted. As a result, you may be refused reimbursement for treatment. Currently, laws protecting the confidentiality and privacy of mental health records are inconsistent and inadequate. As a result, any information given to your health insurance company may not remain confidential by your health insurance company. This information could be released to third parties whom you may not want to have the information (i.e., employers or other insurance companies). A mental illness diagnosis or use of insurance for mental health treatment may affect future insurance coverage (i.e., life insurance premiums might be raised or future benefits denied). Please note: When you ask me to give information to your insurance company, you must give me permission to give them any information about your therapy that they request.

Please initial each of the following: _____ I wish to file insurance for my mental health treatment.

_____ I give Jim Wayland, Ph.D., LPC, LCDC permission to release to my insurance company any information they request in order to handle or determine my claim.

_____ I understand that Jim Wayland, Ph.D., LPC, LCDC cannot fully protect my confidentiality if I choose to file for insurance reimbursement for his services. My signature below means I have read all information provided in this form,

understand the possible consequences of filing for insurance reimbursement and have been given clear answers to the questions I have asked. My signature also means I agree to pay the fee at the time of service and will take responsibility for seeking reimbursement from my insurance company (with documents provided by Jim Wayland, Ph.D., LPC, LCDC). My signature also means I am responsible for paying the full fee for any appointment I schedule but do not show for (i.e., a "no show") or fail to cancel at least 24 hours before the scheduled appointment (i.e., a "late cancel"). I understand my insurance company will not pay for missed appointments.

Signature _____ Date: _____