FEE AGREEMENT AND FINANCIAL POLICY

Karen Muehl Counseling, PLLC

Please review this Fee Agreement and Financial Policy (the "Agreement and Policy"), which describes my schedule of fees for therapy services, charges not covered by insurance, and additional fees. Please be sure you understand the policies regarding cancelations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. If you have any questions about anything, please ask me prior to signing this Agreement and Policy.

Therapy rates and corresponding health insurance billing codes (numbers starting with '90')

90791	Initial Consultation – Individual (50-60 min.)	$150.00
90837	Individual Therapy (60 min.)	$150.00
90834	Brief Individual Therapy (45 min.)	$125.00
90832	Brief Individual Therapy (30 min.)	$60.00
90853	Group psychotherapy (90 min.)	$60.00
90847	Couples Therapy* (60 min.)	$150.00

*Many insurance companies do not reimburse for couples therapy.

Charges not covered by insurance

Records requests	$15.00
Case Management*	$125.00 (pro-rated per 15 min.)
Phone Consultations (11-60 min.)	$125.00 (pro-rated per 15 min.)
Career Testing	$125.00 (includes assessment report)

*Case Management includes indirect services I provide outside our session times such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), coordinating adjunct services, and completing forms or reports.

Additional fees

Late cancelations – fewer than 24 hrs. prior to appointment	$50.00
Missed appointment (first time)	$75.00
Missed appointment (after first time)	$125.00
Non-sufficient funds (bounced) check	$25.00
Past-due accounts – over 90 days	$25.00 per month

PAYMENT

You will be expected to pay for either • each session in full or • your insurance co-payment at the time of services provided under the ***Outpatient Services Agreement,*** which will be given to you along with this Agreement and Policy and my ***Notice of Privacy Practices***. Accepted methods of payment are cash, check, or credit cards. Preferred method of payment is by check, made payable to Karen Muehl Counseling, PLLC. Checks returned due to insufficient funds will incur a fee of $45, which will be charged to your credit card on file (see ***CREDIT CARD ON FILE*** section below).

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INSURANCE REIMBURSEMENT

Blue Cross. I accept and process insurance payments through Blue Cross Blue Shield of North Carolina ("BCBSNC"). If you have insurance with BCBSNC, then I will **(1)** expect and accept payment of your copayment amount at the time of service; **(2)** file your claim with BCBSNC; and **(3)** receive payment from BCBSNC.

Other Insurance. If you have insurance with any other insurance provider, then you are responsible for **(1)** obtaining authorization for treatment and coverage; **(2)** filing claims with your insurer; and **(3)** receiving reimbursement payments from your insurer. You are responsible for informing us of any changes in your insurance information. I will provide you with standard billing information required by insurance companies for processing claims.

_____I agree to (1) allow Karen Muehl Counseling, PLLC ("KMC") to bill BCBSNC directly for services provided under the ***Outpatient Services Agreement***; (2) give KMC permission to release any information the insurance company may require in order to process payment; appoint KMC as my authorized representative to act for me in obtaining payment; (3) assign all of my rights to claims and payment by BCBSNC to KMC; and (4) agree to assist with the claims process as required by KMC and BCBSNC. I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies.

PLEASE NOTE: (1) KMC files insurance as a courtesy to you, and that you (not your insurance company) are ultimately responsible for your bill. (2) If BCBSNC denies a claim filed on your behalf, then you are responsible to pay KMC for the difference between the standard rate and the amount previously paid as copay.

_____I will self-pay for psychotherapy and treatment services provided under the ***Outpatient Services Agreement***.

CANCELATIONS & MISSED APPOINTMENTS

Insurance carriers will not pay for late cancelations or missed appointments. Once an appointment is scheduled, that time is reserved specifically for you. Cancelations must be made at least 24 hours in advance. Although 24 hours is the minimum, if you need to cancel or reschedule please give as much notice as possible. You may notify me of cancelation by phone or e-mail. Late cancelations (fewer than 24 hours before the appointment) will incur a fee of $50. Missed sessions will incur a fee of $75 for the first missed session and $125 for subsequent missed sessions. I will notify you of any late cancelation or missed session fees that you incur, which will charged to your credit card on file.

PAST DUE ACCOUNTS

Amounts past due by more than 30 days will incur a late fee of 1.5% for each month the balance remains unpaid. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, KMC may resort to legal means to secure payment. This may involve hiring a collection agency, an attorney or going through small claims court. If such legal action is necessary, you will be responsible for those costs.

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CREDIT CARD ON FILE

Upon scheduling your first appointment you are asked to provide credit card information which will be kept on file (stored electronically with secure, encrypted, HIPAA-compliant software) to be used for charges incurred for late cancelations, missed appointments, returned checks, or past due account balances. If your card on file is charged, you will be notified of the reason for the fee and the amount charged. A receipt will be e-mailed to you at the address you specify below. You may also request that the credit card on file be used as your preferred method of payment at the time of service.

Type of card
(circle one): Visa MasterCard Discover

Last 4 Digits of Card #:_____[Please have card ready]_____

Expiration: _____

Name on card: _____

Initial here:_____I authorize Karen Muehl Counseling, PLLC to charge this credit card as needed according to the terms specified in this Agreement and Policy.

Signature:_____ Date: _____

Email address: _____

I have read the Agreement and Policy above, and I have been offered a copy for my records. I understand the policy and by my signature below I agree to be bound by its terms in association with outpatient services provided to me by Dr. Karen Muehl. Any and all negotiated exceptions or special arrangements are listed below.

_____
Patient name (printed)

_____ _____
Patient signature Date

_____ _____ _____
Parent/Guardian signature Relationship to patient Date

_____ _____
Karen Muehl, Ph.D. Date

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