

Delta Counseling
Aurora Mandy LMFT #47273
3701 Lone Tree Way
Antioch, California 94509
(925)864-4042

Fee Policy

The services, which appear to be appropriate for you and your family, will be explained to you in the first or second interview/session. The evaluation phase of treatment is used to see what the problem is and how I might be helpful. At the conclusion of this phase you will be asked to help in preparing a preliminary psychotherapy treatment plan. I will be prepared to make specific recommendations to you, to include goals and an estimate of how long the treatment will take.

To meet the cost of the psychotherapeutic treatment services, I have established the following fee schedule: \$90.00 for each individual, 50 minute session; \$90.00 for each 50 minute, family session: or \$25.00 for each group counseling session.

Payment by Insurance

I do not currently have contracts with any insurance carriers other than Medi-Cal. Some insurance carriers will pay “out of network providers”. Often, this would require you to pay a co-payment and to pre-pay for your appointments and obtain an invoice for your carrier for reimbursement. **It is your responsibility to settle the matter with your insurance company as their subscriber.**

We accept cash, credit cards, debit cards or personal checks for payment.

Important Note:

There is a 24-hour cancellation policy. **You are billed for a full session when cancellation is not given prior to 24 hours.**

When I schedule an appointment with you, I cannot give that spot to anyone else. I hold a two consecutive missed appointment policy. After two consecutive missed appointments, we will discuss referral and after care options with you.

If you are more than 15 minutes late without calling, your appointment will be considered missed. If you contact me, it may be possible to reschedule.

Delta Counseling
3701 Lone Tree Way, suite 10B
Antioch, California 94509
Phone (925) 864-4042 —fax (925) 522-8085

Contract for Services

Part II:

1. Counseling Fee: \$90.00 per therapy hour, payable at each session.
2. Billing name _____ Relationship to client? _____
3. Address _____ City _____ Zip Code _____
4. Home Phone () _____ Work Phone () _____

It is the policy of Delta Counseling that counseling services are paid at the time of each session. If these services are covered by insurance, the client pays for therapy at each visit and a statement is sent monthly to be submitted to the insurance company for reimbursement directly to the client.

A minimum of 24 hours notice for cancellation is requested or client will be billed for the session.

You have received a separate confidentiality statement and disclosure information for counseling services.

Part III: (Complete if you are using insurance)

1. Insurance Company _____ Policy Number _____
2. Address _____ City _____ Zip Code _____
3. Group Number _____ Policy Holders SS# _____
4. Do you agree to have the Therapist reimbursed directly? [] Yes [] No. If yes, complete Part IV.

I HAVE READ THE ABOVE AND I AM IN AGREEMENT AS STATED:

Client Signature _____ Date _____

Client Signature _____ Date _____

Therapist Signature _____ Date _____

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ASSIGNMENT OF INSURANCE RIGHTS

Part IV:

Client Name: _____

Policy No. _____

Group No. _____

Insurance Company _____ **Phone Number** _____

Address _____
City, State Zip Code

Primary Care Physician _____ **Phone Number** _____

Address _____
City, State Zip Code

I hereby assign all benefits to my therapist, for services rendered by her and covered under the above policy. I hereby authorize Aurora Mandy, LMFT #47273 to bill my insurance company with the information necessary to process my claim.

Signature _____ Date _____

Relationship to Client _____