

Turning Pointe Counseling & Consulting LLC (TPCC)
Kelly Bulinski MSEd, LPCC-S
Statement of Fees and Payment Policy

Payment for Services:

Payment, including co-payments if utilizing in-network benefits, is expected at the beginning of each session. Payment may be made in the form of cash, check, credit card, or Health Savings Account (HAS) cards. You may fill out a *Credit Card Authorization Form* providing billing information to be kept on file. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service.

Standard Fee Rate:

- **Individual:** Initial Session: \$135.00 55 Minute Session: \$110.00 45 Minute Session \$100.00
- **Couples/Family:** Initial Session: \$150.00 55 Minute Session: \$130.00

In-Network-Insurance:

If TPCC is a provider for your Primary Insurance Plan, we will submit claims for reimbursement. Co-payments and appointment fees applied to you deductible are required to be paid in full at each session. Client acknowledges by signing below that they are responsible for the full amount of the fees charged if provided insurance does not pay. If client's insurance either terminates or changes during the course of treatment and TPCC does not have a contract with new insurer, the below out-of-network-insurance policy applies.

Out-of Network-Insurance:

TPCC does not bill out-of-network insurance directly nor secondary insurance policies. Depending on client's plan, most insurance companies will reimburse a percentage of the session cost as out-of-network. If client choose to use out-of-network benefits, please verify benefit coverage prior to first visit. Documentation may be provided by therapist for client to submit to insurance company for reimbursement. Upon request: a "Superbill" receipt will be provided for each date of service. The information stated on the "Superbill" receipt includes therapists credential, license number, tax ID, NPI#, client information, diagnosis code, and cost of each session.

Sliding Fee for Service: Turning Pointe Counseling & Consulting, LLC offers a sliding fee for service, details of which are available on the website: www.turningpointecc.com or by asking your therapist for a copy of the sliding fee form. Please note: sliding fees are based on income. If client chooses to use either in-network or out-of network insurance benefits to pay for therapy, sliding fees do not apply.

Cancellations and No Shows:

If you (client) need to cancel an appointment please do so no later than 24 hrs. prior to your scheduled appointment. My below signature acknowledges I (client) understand I will be charged a minimum of \$75.00 for a late cancellation (appointments cancelled without 24 hour notice) and a full-rate fee will be charged for appointments cancelled within 6 hours of my appointment time or for not showing for an appointment. **Please note:** cancellation or no/show fees is billed to client personally and are not covered by insurance. Client is responsible for paying this fee prior to next scheduled appointment. A bill may be mailed directly to clients who do not show up for, or cancel an appointment. Clients who do not keep scheduled appointments may be terminated.

Miscellaneous and Paperwork Fees:

The below fees are not covered by insurance and are the responsibility of the client.

- Paperwork such as filling out forms or writing letters at the request of the client will incur an additional client fee for service billed at \$55.00 per half- hour of therapist's time.
- There is a \$20.00 fee for any returned checks.
- **Please note:** In the event your therapist is served with a subpoena or requested to provide information for legal issues, a fee of \$150.00 per hour will be charged for your therapist's time in preparing for, and participating in, such legal action. These include (but not necessarily limited to): responding to a subpoena, release of information request, written reports, paperwork needs, consultation, phone communication, travel and wait time involved in attending deposition, hearing or trials. Additionally, the client is responsible for any legal fees incurred by your therapist due to involvement in such legal actions.

Agreement

I (Client) have read (or have had read for me) and understand the information outlined in this document pertaining to all applicable fees & payments for services. My (Client) signature below indicates my agreement to comply with the above policies and procedures.

(Signature of Client)	(Print Name)	Date: ___/___/___
(Signature of Client)	(Print Name)	Date: ___/___/___
(Signature of Parent/Legal Guardian)	(Print Name)	Date: ___/___/___
Therapist's Signature: _____		Date: ___/___/___

Kelly Bulinski MSEd, LPCC-S