Austin Wellness PLLC

Austin Wellness, PLLC
www.austin-wellness.com
10010 Anderson Mill Rd.
Austin Texas 78750
512-257-0050

FEE POLICY
Client - Therapist Agreement

As your therapist, I am committed to providing you with the best possible care. In order to achieve these goals, I need your assistance and your understanding of my payment policy.

FEE RATE:

Diagnostic Assessment	(1 hour)	$170	(initial session)
Individual Therapy	(50 minutes)	$140	
Individual Therapy	(1 ½ hour)	$210	
Professional Consultation	(per hour)	$140	
Workshops, Seminars, Lectures		individually agreed upon	

INSURANCE PAYMENTS:
The client is responsible for providing accurate and complete information regarding insurance on the registration form. Austin Wellness does not guarantee that your insurance will pay your claim. You are responsible for the account balance and for deductibles and co-payments required by your insurance.

MISSED APPOINTMENTS:
The client agrees that if he/she is unable to keep an appointment, he/she will provide a minimum of 24 hours prior notice to the therapist by leaving a message or speaking with the therapist directly. If an appointment is canceled or missed without 24 hours notice, the client understands that he/she will be billed full fee for the session. In this event the bill will reflect a late cancellation and not a clinical session. Exceptions may be made for emergencies. Your insurance company will not pay for your missed appointments.

PAYMENT METHOD:
Payments for services are expected at the time of the appointment. Payment may be made by check or cash. Should the client's account remain unpaid for 30 days, the therapist reserves the right to suspend or discontinue treatment until the charges are paid in full or a suitable payment arrangement is agreed to in writing by both the client and the therapist. If payment is not made, there will be a brief time period devoted to the termination of the work where the clinician will offer referral assistance to the client. If legal means are required to secure payment, legal costs will be charged to the client.

TELEPHONE CONSULTATION:
The standard fee will be charged on a prorated basis for telephone consultation with the client. Phone contacts with family or friends will be approved by the client in advance and a release of information will have been signed by the client. Brief phone contacts with the client of less than ten minutes duration and calls relating to scheduling issues will not be billed.

CONSULTATION:
The client understands that until a plan of treatment has been developed and agreed upon by both the clinician and the client during the intake process, all services provided to the client are consultative in nature. The therapist will evaluate with the client the nature of the client's concerns during the first few meetings, and will determine whether the clinicians can treat the problem as presented, or whether another referral would be more appropriate. As a consultant, the therapist assumes no obligation to provide continuing services to the client. In the event the therapist recommends services elsewhere, the client will be offered referral assistance.

RETURNED CHECKS:
A processing fee of $30.00 will be charged for all returned checks.

TERMINATION OF TREATMENT:
The client may terminate treatment at any time without moral, legal or financial obligation beyond payment for sessions already rendered. It is expected that the therapist and the client will discuss the prospect of termination so that both parties will have clarity concerning any details that might need attention as part of the termination process. If the client cancels or misses a scheduled appointment and does not contact the therapist within 30 days of the missed appointment date, it will be understood that the client has terminated treatment. Should the client make contact with the therapist at a later date requesting additional services, the therapist may choose to see the client on a consultative basis, or may choose to refer the client for services elsewhere. The therapist has no further obligation to the client once treatment has been terminated.

The client, by signing below, indicates that he/she fully understands and agrees to the above stated policies.

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PRINTED NAME OF CLIENT

____________________________ ____________________
SIGNATURE OF CLIENT **DATE**

____________________________ ____________________
SIGNATURE OF THERAPIST **DATE**