CrossPath Counseling & Consultation

APPOINTMENTS AND FEES

The first therapy session is **60** minutes with a **$175** fee. Further appointments are usually **50** minutes unless otherwise arranged and the standard fee is **$140**. Late cancel or no show will result in a $**70** fee.

The first ARNP/Medication Management appointment is **90** minutes with a $**300** fee. Further appointments are usually **30** minutes unless otherwise arranged and have a standard fee of **$170. Late cancel or no show to these appointments will result in a $200 fee including the first appointment.**

We provided reminder text or emails before your appointment as a courtesy, but not receiving one does not excuse a missed appointment. You are responsible for remembering your scheduled appointments.

We ask for **24 hours** cancellation notice, or it will be considered a late fee. Cancelations can be made by phone or by email.

Payment is required at each session unless otherwise arranged.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care. We will bill your insurance for you as a courtesy. Please note:

- Patients are responsible for knowing their insurance. If your insurance requires a prior authorization, it is your responsibility to obtain one.
- The patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of copays, coinsurance, deductibles, and all treatment not covered by their insurance plan.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include: Charge for returned checks, charge for missing appointments without 24-hour notice, ect.
- **Insurance only covers 60min therapy appointments. Any therapy appointment that exceeds 60min will not be full covered by insurance and patients will be responsible for the outstanding amount.**

By my signature below, I hereby authorize assignment of financial benefits directly to Crosspath, LLC and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

_____ _____

Signature Printed Name

_____ _____

Client Name (if different then above) Date