Payment Contract for Services

In order to provide best possible service to our client, Lotus Hope Counseling, LLC. adopted the following financial policies.

My signature below indicates that I am responsible for full payment to Lotus Hope Counseling, LLC. in the event that any or all payment denied by insurance or other third-part payer. We require that at each session you pay your co-pay or 100% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. Account balances must be paid prior to or at the beginning of the next session. Continuation of services may be dependent on having your account in good standing.

Clients utilizing their insurance benefits to cover a portion or all of their fees are responsible for any balances which result from the insurance company denying payment. We make every effort to verify coverage and identity financial liability (such as deductions, co-pays etc), however, it is ultimately the client's responsibility to know their coverage and resolve any non-payment issues directly with their insurance company. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Lotus Hope Counseling, LLC.

I understand and agree to the following fees:

First Session (Intakes) $100
Individual Session up to 52 minutes $70
Individual Session 53 minutes $100
Family Session $75
Group Session $45 / per hour
Appearance fee for provision of testimony $100 / per hour
Writing a letter on client's behalf (judge, lawyer, probation). $20 per request of letter
.25 per page for copies of client's file
Missed Appointment Fee: $60

The client is responsible for any and all postage fees for sending through the U.S. Mail my copies, letters, notices, invoices, etc.

To ensure compliance with these policies, we require a credit card be kept on file. Please completed the Credit / Debit Card Payment Consent Form.

Credit / Debit Card Payment Consent Form

I, _____, authorize to charge my credit/debit/health account card for professional services at our scheduled appointment time. If I do not cancel before 24 hours, I recognize that Lotus Hope Counseling, LLC will charge my card as a late cancel or no show if I do not show up for the appointment. I will be billed $60 as a no show/late cancellation fee.

I verify that my credit card information, provided below, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing this form that if no payment has been made by me, my balance will go to collections if another alternative payment is not made within thirty days.

Card Information:

Card Type: American Express Discover Card Master Card Visa

Name on Card as it appears:_____

Card Number:_____

Expiration Date: _____

Billing Zip Code: _____

Security Code: _____

Client's Signature: _____ Date: _____

Card Holder Signature: _____ Date: _____

Relationship to client: _____

I was offered a copy of this Policy and I ☐ accepted it ☐ declined it. Initial here: _____