Catalyst Counseling, LLC

Fee Agreement

Client Name: _____ **Date:** _____

Payor Source

_____ **Medicaid:** Caresource Molina Healthcare of Ohio Paramount Advantage Amerigroup Buckeye Health Plan United Healthcare Community Plan of Ohio Ohio Medicaid Aetna Better Health of Ohio

***No copay or out of pocket costs for clients with Medicaid plans.**

_____ **Private Insurance:** Aetna Anthem Cigna Compsych (EAP) Humana Humana Military Medical Mutual United Healthcare Optum Meritain Health Other: _____

Copay:_____ **Deductible:**_____

Each person is responsible for his/her copayment and/or deductible. If you have a deductible to meet, you will pay the self pay rate until the deductible is met. Catalyst will provide a statement for network and out of network insurance companies so that fees paid will count towards your deductible. If the copay or deductible is different than the initial amount reported, it is your responsibility to pay the remaining balance to Catalyst Counseling, LLC upon notification.

Self Pay:	**Diagnostic Assessment:**	**$103.00**
	Therapy Session:	
	• **30 minutes**	**$41.00**
	• **60 minutes**	**$82.00**
	Group Therapy Session	**$20.00**
	Missed Appointment/Late Cancellation:	**$50.00**

I, _____(parent/guardian), agree to pay for up to _____ sessions/month at the _____ minute time interval at the self-pay rate stated above. I agree to pay for up to a total of _____ diagnostic assessment sessions at the rate stated above. I agree to pay for _____ group sessions/month at the rate stated above. I authorize Catalyst Counseling, LLC to bill my credit card (card #_____, expiration date_____, 3 digit code on back of card _____) via the Square App after providing each session. I authorize Catalyst Counseling, LLC to charge my credit card in the case of an emergency (imminent risk of harm to self or others). I understand that I will not be present every time my card is billed as sessions are provided at school and that I will receive an emailed receipt after each session. I understand that I need to notify my therapist in writing to discontinue services and for my credit card to stop being charged for services.

X_____

Client Responsibilities and Fee Information

- Each person is expected to pay his/her fee at the time of service.
- Notify your therapist if there are any changes to your insurance benefits or if your insurance is discontinued.
- No shows or cancellations without a 24 hour notice will be charged $50.00, which is not reimbursable by insurance.
- All inquiries into pre-certification, benefits, treatment plans (if necessary), coverage, etc. are the client's responsibility.
- Payment is expected at the time of service and the client has the ultimate responsibility for their account and making sure insurance payment is received if using insurance. If a claim is denied it is the client's responsibility to pay their account upon notification of denial at the insurance reimbursement rate.
- If payment is not received for services rendered in a timely manner I understand that Catalyst Counseling, LLC will release my information to a third party Credit agency to attempt to collect my debt. The information provided to the Credit agency will only be demographic information in order to collect this debt.
- Catalyst Counseling, LLC has your permission to release your protected health information to your insurance company and CompuClaims, LLC (Kathy Dye) to submit billing claims. You authorize Catalyst Counseling, LLC to be paid directly by your insurance company. ***Please contact Kathy Dye (Claims Representative) at CompuClaims, LLC at 937-665-0402 with billing questions.***
- In order to receive services from Catalyst Counseling, LLC you are agreeing to the conditions outlined above.

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Client or Parent/Legal Guardian Signature Relationship to Client Date

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Therapist Signature Date