

**Fees, Payments, and Cancellation Policies**

**The Therapeutic Hour:** I, Ara Christensen, LMFT, am available for regularly scheduled therapeutic sessions. The therapeutic session hour consists of 54-60 minutes. When you schedule a session with me, we reserve a therapeutic hour dedicated to you and your therapeutic work.

**Payments are due at the time of each session.** Your fees can be paid by cash, credit card, or personal check (a $35 fee will be added to any returned checks). You will be given at least 30 days notice if fees should change. Current standard fees are as follows:

**Therapy Services: Standard Fees:**

54-60 minute therapeutic hour: $120

54-60 minute therapeutic teletherapy hour: $120

Consultations, Paperwork Preparation, etc. $120 per hour prorated

\*\*There is no charge to briefly discuss appointment time details by phone or email.

\*\* Longer or shorter sessions are charged proportionately.

**Cancellation Policy:** If you decide you do not want or cannot use the therapy time you have scheduled, I ask you give me 24 hours notice so I may make that time available to someone else, and so such a cancellation will not be a financial hardship for me. Cancellations must be made by phone or email. **Without 24 hours notice, or if you fail to come to the session (“no-show”), I will ask you to honor your responsibilities for that session time by paying the full fee. Late cancellation and missed session fees will be charged at the time of the cancelled or missed session.** *\*\*Please be aware insurance companies do not pay for late cancellations or failed appointments. You are responsible for 100% of my regular hourly fee in these cases.* A credit card will be kept on file for any missed or unpaid balances.

**Cancellation Exceptions:** If the circumstances which have kept you from keeping our scheduled appointment are an emergency of a medical or family nature your session fee will be waived. Please note that habitual emergencies will result in your reserved session slot being cancelled and made available to other clients. Such cancellation will be communicated by phone or email.

**Inclement Weather:** If inclement weather is an issue I will call to inform you sessions will not be occurring in the office during such weather. I will offer you a telephone or teletherapy session at your regularly scheduled time. If you would prefer, in such circumstances, we can reschedule your appointment at no charge.

**Extended Sessions:** Occasionally it may be necessary to continue a session rather than stop during therapeutic intervention. This is billed on a prorated basis based upon my standard fee. If this is the case I will communicate at the end of session your option to extend session on a prorated billing basis and obtain your approval of such extension before continuing session. Please note insurance companies do not cover extended sessions. It will be your responsibility to cover the additional prorated fee at my standard rate in these cases.

**Financial Hardship:**  If you are having difficulty paying your fees on time please approach me to discuss this circumstance. Upon your request we can discuss a financial hardship fee. If your bill remains unpaid for more than 60 days this may result in termination of therapeutic services.

**Insurance Billing Out of Network:** If you would like to utilize out of network billing please contact your insurance company to verify they accept “super bills” and reimburse for therapeutic services rendered outside of their network of providers. If you choose this option BPT will provide a “super bill” to you to submit to your insurance company for reimbursement after you have paid BPT the standard fee for services. \*\*\*Please note BPT cannot be responsible for services your insurance company chooses not to cover and reimburse.

**\_\_\_\_\_ I will be submitting a “super bill” to my insurance company for reimbursement.**

**Insurance Billing In Network:** If you would like to utilize your insurance to bill directly for services rendered please contact your insurance company to verify that I am an in network provider for your insurance policy. You will need the following information to verify my network status.

1. Tax ID: 86-3441724
2. NPI: 1285177667
3. Service Location: 2123 113th Dr SE, Unit A, Lake Stevens WA 98258, or Teletherapy

Once you have determined whether I am an in network provider it is important to also determine what deductibles, copays, and/or coinsurance amounts you may be responsible for. Additionally, I will periodically inquire about changes to your insurance, however, it is your responsibility to inform me when insurance information or coverage for you has changed.

Additionally, it is important to be aware that if you choose to have me bill your insurance company directly for services rendered your Private Health Information will be utilized to process claims and medical necessity of treatment rendered. This includes but is not limited to, type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

\_\_\_\_\_\_ **I choose to authorize Ara Christensen, LMFT to bill my insurance company directly for services rendered and I am providing Ara Christensen with my insurance information. I recognize this requires the sharing of PHI between my insurer and Ara Christensen, which are both covered entities under HIPAA. I authorize my insurance company to pay Ara Christensen, LMFT directly. I further understand that I will be responsible for any amounts the insurance company chooses not to cover.**

**Medicare/Medicaid:** I am not contracted with Medicare or Medicaid. Therefore, these insurers will not pay for my services. If at any point you become a member of Medicare or Medicaid It is your responsibility to inform me that you have done so. Further arrangements will need to be made including, but not limited to, termination of services.

Our agreed upon billing arrangement will continue as long as therapeutic services are rendered. If you wish for this arrangement to end please submit this request in person, by phone, by email, or certified mail. It is your responsibility to pay for all services rendered before you end our therapeutic relationship.

**Agreed upon payment schedule between \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (client) and Blue Petal Therapy, LLC:**

Date Sessions to begin: Agreed upon Fee:

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Billing Information**

Please indicate the form of payment you wish to use for services provided by Blue Petal Therapy, LLC. The following forms of payment are accepted: Visa, MasterCard, Discover, Cash and Check. For services not exchanged in person, fees will be deducted from the designated account at the time services are provided. The card listed below will also be billed for missed sessions, or cancelled sessions with less than a 24 hour cancellation notice.

**Client Information:**

Client Name (First, MI, Last) Date of Birth

(Name of person paying for services if different from above)

Billing Address: Street/City/State/Zip

Primary Phone Secondary Phone

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Email

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**Credit/Debit Card Information:**

Please provide your payment information below: Indicate the primary card you wish to use for payment, and a secondary card for any returned checks, declined or cancelled cards.

**Primary: Card Type (circle one) Visa Master Card Discover**

Card Number Expiration Date 3 digit security code

**Secondary Card: Card Type (circle one) Visa Master Card Discover**

Card Number Expiration Date 3 digit security code

I authorize any service fees to be deducted from the credit or debit card ending in \_\_\_\_\_\_\_\_ or \_\_\_\_\_\_\_(provide the last four digits of the card).

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_