**Richmond Restorative Therapy**

**Carol McLaughlin, LCSW**

**8401 Patterson Ave, Suite G-102**

**Richmond, VA 23221**

**Consent to Bill for Services**

**Use of Insurance:**

As a part of receiving psychological services through Richmond Restorative Therapy, I understand that I will be responsible for the financial expenses incurred as the result of my participation in treatment. I further understand that I may elect to use a third party payer, i.e. medical insurance, to help cover the cost associated with treatment. However, I understand that if I elect to use a third party payer to help offset the cost of my treatment, I will be required to consent to the release of information for billing purposes. This will definitely mean releasing information regarding the dates and frequency of visits, the release of a formal diagnostic impression, and at times may constitute the release of treatment planning information.

**Charges for Services:**

Diagnostic Assessment: $175.00

Psychotherapy Session: $125.00

Missed Appointment/Late Cancellation (without giving 24 hours prior notice): $ 100.00

Phone Calls: $25 for calls lasting over 15 minutes, $50 for 30 minutes, etc.

Education/Support Group: $30 per hour

Letters/Reports for court, school, etc: $30.00 per page

**Payment:**

I understand that payment is expected at time of service. If I wish to pay for services out of pocket, or for the purposes of making my co-payment, should I elect to use my insurance, I may make payments via credit card, cash, or check. I understand all checks returned unpaid will be subject to a $25.00 service fee, and if they remain unpaid for more than three months, may be turned over to a collection agency for the purpose of recovering lost funds.

**Insurance Coverage, Incurred Expenses and Authorization for Treatment:**

If I chose to use medical insurance, it is important that I be aware of my coverage and limits. I am responsible for amounts and/or services not covered by my insurance. I am also responsible for payment of amounts not covered because of failure to obtain a referral/authorization or not following necessary guidelines set by my insurance company for accessing mental health benefits. I understand I will be charged $100.00 for missed or cancelled appointments unless notification is given at least 24 hours prior to the time of the appointment. I understand that insurance companies do not cover the costs of missed appointments and I will be billed directly.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

[ ] wish to use my medical insurance to off-set the cost of treatment, and in so doing give Richmond Restorative Therapy and Carol McLaughlin, LCSW permission to release any information necessary to process this claim and collect payment for the services rendered. I permit direct payment to my therapist any benefits due me for services rendered. I understand I am financially responsible for all services rendered, if not otherwise satisfied through my medical insurance.

[ ] do not wish to use any medical insurance benefit to cover services I receive through Richmond Restorative Therapy and Carol McLaughlin, LCSW. I understand that I am financially responsible for all expenses incurred for my treatment, and will make all payments at the time of service.

Client Name Client Signature Date