**POLICY, FEES, PAYMENT, INSURANCE AND SCHEDULING**

***for Amy Sander Montanez, D.Min., LPC, LMFT***

***DBA: Personal and Family Growth Associates, Inc.***

The fee for a 50-55 minute session is $140.00 unless your therapist indicates otherwise. Please plan to pay the full fee after each session unless otherwise arranged in advance. You will not be billed. However, a copy of your charges and payment record will be made available upon your request. You may pay with credit card, cash or check made out to your therapist (or the business name). If you pay by check, your check will be deposited into your therapist’s account and by nature of its traveling to the bank and being handled by bank professionals, confidentiality cannot be guaranteed. If you are paying by a credit card left on file, you will be notified before a transaction is made.

Your appointment time is reserved for you alone. Without sufficient prior notice, it cannot be given to anyone else. **You will be charged the full fee for any missed appointments unless you provide cancellation notice 24 hours in advance or advise us in the event of an emergency.** Appointments will be scheduled after sessions or you can call the office at 803-254-5650, and leave a message for your therapist.

Most therapists do not charge for brief telephone contacts; however, you will be charged for telephone sessions, written evaluations, official letters, court appearances, or meetings with collateral contacts.

We do not file with insurance companies but will be glad to provide whatever information your particular plan requires so that you may file for reimbursement. Companies often require that a diagnosis be assigned before they will pay. If you find that this is necessary with your plan, you will be advised of a diagnosis code for insurance purposes.

Insurance companies and policies differ greatly in their choices of what types of providers and mental services are covered. There are sometimes confusing and seemingly arbitrary restrictions on reimbursements. With your permission, your therapist will attempt to provide to you whatever documentation of your services your company requires. If you are relying on your coverage to pay for therapy, you should get direct confirmation from the insurance company that they will pay out-of-network mental health benefits and what percentage they will reimburse. **You are responsible for the full fee at time of service. \*\*Please be aware that using insurance to cover mental health fees is an automatic agreement to Release of Information to your insurance company.**

**POLICY, FEES, PAYMENT, INSURANCE AND SCHEDULING page 2**

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I have read “Policy, Fees, Payment, Insurance, and Scheduling” and understand my responsibilities as stated. I understand that I am responsible for payment whether or not my health insurance covers treatment.

Further, I understand that although the location of service is at Wholistic Therapy and Coaching Center of the Midlands, this is not the service provider and I agree to hold harmless any other service provider at this location.

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person responsible for payment if different than above:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_