

Lucy Heggenstaller, M.S.W., L.C.S.W., B.C.D.
3 Hospital Drive, Suite 308
Lewisburg, PA 17837

FINANCIAL POLICIES

These are my financial policies, which I require that you read and accept prior to treatment.

FEES

The fees billed for outpatient mental health visits are as follows:

Intake Assessment (First Appointment)	\$135
Individual Session (45 minutes)	\$90
Individual Session (75 minutes)	\$135
Family Session (45 minutes)	\$105
Collateral Family Session (45 minutes)	\$105
Group Therapy (75 minutes)	\$50

Additional information about my fees:

If you pay for your visits yourself, you may reserve a session of any length.
You may be eligible for a cash discount if you have no mental health coverage.
If you arrive late for an appointment, you will be billed for the length of time reserved.
Cash, checks, and major credit cards can be accepted as payment.

No Show/Late Cancellation Fees: To avoid no show or late cancellations fees, cancel with at least 24 hours notice. Messages are accepted 24 hours a day on my office answering machine.

First time no show/late cancellation fee	\$25
Sequential no show/late cancellation fee	Full cost of your scheduled visit.

Court Fees: If you become involved in legal proceedings that require my participation, you will be required to pay for my professional services including preparation, court time and transportation, even if I am called to testify by another party.

\$150/ hour

Miscellaneous Fees:

Telephone consultations	\$22.50/ quarter hour
Preparation of records or summaries	\$22.50/quarter hour
Consultations with others at your request	\$25/quarter hour
Attending meetings at your request	\$25/quarter hour

INSURANCE BILLING

If you have mental health benefits, please call your plan to clarify your coverage. Co-pays and deductibles for mental health services may or may not be the same as for other health benefits. If you wish to utilize mental health benefits, please complete a "**MENTAL HEALTH INSURANCE INFORMATION**" form.

If I am a participating provider (or in-network provider) with your insurance, I will bill for my services on your behalf. If, for any reason, your insurance does not cover my services, you will be responsible for payment. If you have a co-payment, it is expected at the time of service.

If I am not a participating provider with your insurance, payment in full is expected at the time of service, unless you have negotiated an agreement with me about this in advance.

(Please continue to Page 2 to sign your consent.)

AGENCY REFERRALS

If you have been referred to me by an agency that is responsible for payment of your services, you are responsible to maintain a relationship with that agency through the course of your treatment. If this is the case, for you or your child, please list the referring agency information here:

Agency	Contact Person	Phone Number
--------	----------------	--------------

Understand that agencies cover mental health treatment. They will not pay for missed appointments or appointments that were cancelled within 24 hours. **You, not them, are responsible for No Show or Late Cancellation Fees.**

EMPLOYEE ASSISTANCE PROGRAMS

If you have been referred to see me by your EAP through your workplace, please be advised that there are likely limitations to the length of your care. Some EAPS also prohibit clients from continuing to see the same therapist with their insurance, something referred to as self-referral. If you have questions about how this may affect your treatment, please ask me.

CONSENT

I (patient, patient's parent or guardian) agree that it is my liability and responsibility to pay in full for charges for services on a timely basis. Payment is expected within 30 days of the billing date. If my account becomes delinquent, I agree to pay all costs for collection of these charges, including those charged by collection agencies, attorneys or court costs.

My signature below indicates that I have read and agree to the financial policies listed above.

Client signature

Date

Parent or Guardian signature

Date