Inner Strength Counseling
Eleanor Salemi, LCSW
FL Lic. SW9620/EIN 27-1980579

Payment Contract for Services

Name(s): _____
Address: _____ City: _____ State: _____ Zip: _____
Bill to: Person responsible for payment of account: _____
Address: _____ City: _____ State: _____ Zip: _____

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES

PART ONE FEES FOR PROFESSIONAL SERVICES

I (we) agree to pay Inner Strength Counseling a fee of:

____ $135.00 for initial intake session for individual / $150.00 for initial intake session for couples or family

____ $ 95.00 per session for individual / $125.00 for couples or family counseling

____ $ 25.00 per group counseling session for each participant

____ $_____ for initial intake session

____ $_____ per _____ minute session for _____

The client understands that *the client, not the Ins. Co. and/or EAP*, will be held responsible for the following fees should they occur and that the client will be notified ahead of time by Inner Strength Counseling, LLC, if the client is to be charged:

- A fee of $ $50.00 is charged for missed appointments or cancellations with less that 24 hours' notice. This fee is waived in the case of family emergency or illness.
- $300 an hour if subpoenaed to appear in court on the client's behalf.
- $25 per quarter hour to write up case summaries to other professionals/parties regarding the client's care. Charges associated with these services will be due prior to the other professionals/parties receiving said documentation.
- $1 per page should the client's records be requested to be faxed, mailed, and/or emailed to other professionals/parties regarding the client's care. Charges associated with these services will be due prior to the other professionals/parties receiving said documentation.
- Postage to send said documents to other parties.
- Phone calls lasting more than 15 minutes will be charged at the rates listed above.
- **E-mail Policy**: I do not do therapy by e-mail or text. I prefer to use e-mail or text only to arrange for appointments or for cancelling appointments. Please do not e-mail me information related to your therapy, as it is not completely confidential. Be aware that e-mails between us become part of your legal record.
- **Social Media Policy**: I do not accept "friend requests" or contact requests from current or former clients on social networking sites (Facebook, LinkedIn, etc.) out of concern for your confidentiality and my privacy. It may also blur the boundaries of the therapy relationship.

My initials indicate I have read and understand the above. (please initial here _____)

PART TWO CLIENTS WITH INSURANCE (DEDUCTIBLE AND CO-PAYMENT AGREEMENT)

This clinic has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

ESTIMATED INSURANCE BENEFITS

1) $ _____ Deductible amount (paid by insured party)
2) Co-payment _____ % ($ _____/clinical unit) for first _____ visits.
3) Co-payment _____ % ($ _____ /clinical unit) up to _____ visits.
4) The policy limit is _____ per year: _____ annual _____ calendar

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We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services that are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be nonefficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in **Part One** above.

It is our policy to collect the full fee for professional services at the time of service. We will be happy to provide you with an invoice for services rendered for submission to your insurance provider.

PART THREE ALL CLIENTS

Payments are due at the time of service. Cash, check, Debit/Credit cards are accepted as payment. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 30 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: (print) _____

Person responsible for account: (sign) _____

Date: _____

801 West Bay Dr., Ste. 422, Largo, FL 33770
Tel. 727.418.0735/Fax 866.706.0538

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RELEASE OF INFORMATION AUTHORIZATION TO THIRD PARTY

I (we) authorize Eleanor Salemi, LCSW to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material)to _____ for the purpose of receiving payment directly to Inner Strength Counseling, LLC.

I (we) understand that access to this information will be limited to determining insurance benefits and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____
(print name)

Person(s) responsible for account: _____ Date: _____
(sign name)

Person(s) receiving services: _____
(print name)

Person(s) receiving services: _____ Date: _____
(sign name)

Person(s) or guardian(s): _____
(print name)

Person(s) or guardian(s): _____ Date: _____
(sign name)

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