David Phillips. LMHC 1002 Tenth Street, Snohomish, WA 98290 (425) 953-4361

FEE AGREEMENT

Fee arrangements are as follows. Ask if you have any questions.	
Intake Session: All Payment amounts are assuming deductible has been met.	$200
Your Payment:	$
Individual 45-50 min:	$123
Your Payment is:	$
Individual 53-60 min:	$180
Your Payment is:	$
Family Session w/ or w/out Patient:	$130
Your Payment:	$
Report Writing/Telephone Calls:	$3.00 per minute
Any returned check that are NFS/Any Declined Credit/Debit Transactions	$40.00/$20.00
60 day past due accounts are charged:	$5.00 a month
The late Cancellation/No Show charge for less than 24 hours notice:	$100.00
Legal fees	$150/hour

The terms described in the Office Policy, State Required Statement and the Notice of Privacy Practice have been read and understood. The fee arrangement has also been made clear to me. I affirm that all the information I have given is correct and complete. I authorize David Phillips, LMHC to provide services to me or my child. I have been given copies of all the above mentioned including this fee agreement.

_____**Yes or No**_____

Patient's Signature or Parent\Legal Guardian Date Adolescent made aware of 24 hour notice?

_____

Therapist Signature Date

Authorization for use or disclosure of protected health information to Third Party Payers

I authorize David Phillips, LMHC to obtain and/or disclose the following protected information: benefits, eligibility, demographic information, billing information, diagnosis, treatment plan, current treatment update, discharge/transfer summary, assessment and/or progress in treatment for _____, (date of birth _____), who is either my child/guardian or myself.

The purpose of this disclosure of information is to bill and receive payment from your insurance company managed care organization or other third party payer. Only the minimum necessary information to obtain benefit eligibility and coverage information as well as to submit claims for payment and to comply with medical necessity and utilization review purposes will be disclosed.

Recipients of Protected Healthcare Information
Name of Insurance Co. EAP and/or Managed Care_
_____

Revocation: It is my understanding that this authorization can be revoked in writing at any time, except to the extent that substantial action may have already been taken in reliance on it, including provision of health care services requiring subsequent disclosure to effect payment.
Duration: If not previously revoked, and provided there are no obligations imposed by my health insurer in order to process or substantiate claims made under my policy, this authorization will expire when benefit claims are no longer pending and my account has been paid in full
Signature: I understand that I have the right to refuse to sign this authorization and that my refusal will not be made a condition of my treatment. However, failure to sign this authorization will prevent me from using insurance benefits or benefits from any third party payer to pay for my treatment. My signature below authorizes use and/or disclosure of protected health information for the above purpose.

Signature:_____Date_____

Client, Parent/Legal Guardian