Charlotte Therapy Associates
Diane Yee, MS, LPC
5200 Park Rd, Suite 219
Charlotte, NC 28209
704 705-4550

CLIENT CONSENT FOR TREATMENT AND BILLING AGREEMENT

I hereby give Diane Yee, MS, LPC, to provide counseling services to:

_____ _____
Client Name Date of Birth

I understand that Diane Yee, MS, LPC will provide the following service(s) to me for the indicated fees:

Cost of Treatment:

$150.00 Initial session (60-75 min)	$120.00 Individual Therapy (50-60 min)
$130.00 Couples or Family Therapy (60 min)	$165.00 Couples or Family Therapy (75-90 min)
$120.00 Consultation or Report writing (per hour)	$120.00 Case Management (per hour)
$120.00 Phone Calls per hour (billed after 10 min.)	$ 2.00 Credit Card processing fee

$ 30.00 Emails requiring 15 min. or more (billed in 15 min increments)

I understand that payment for services are expected at the conclusion of each session and that a receipt will be provided for me. If insurance arrangements have been made prior to the session and a co-pay is applicable, it is due at the time of my session. If for any reason your insurance does not agree to pay your fee (co-pay or percentage), **you are ultimately responsible for payment in full**.

In order to guarantee payment a credit card must be put on file and will be billed only with notice by Diane Yee, MS, LPC for a missed or unpaid for appointment.

Credit Card #_____ **Exp.**_____

Billing Address Zip Code_____ **VISA** **MASTERCARD**

Your insurance company has informed me that your benefits are as follows:

Insurance Company:_____**Deductible:**_____ **Co-pay:** _____

Max. # of sessions/Amount_____ **Per Calendar Year/Benefit Period:**_____

I agree to allow Diane Yee, MS, LPC, bill my insurance company directly for service provided and understand that the insurance company may request information in order to process payment. I give her permission to release the necessary and requested information to the insurance company.

If payment is not made at the time of my appointment and it is not a matter of special arrangement agreed upon by myself and Diane Yee, MS, LPC, payment must be made within 7 working days of the session in question AND before a new appointment can be scheduled. If payment is not made within this time period, Diane Yee MS, LPC has the option of informing me, in writing, that future services might be jeopardized and even discontinued. I understand that she can provide me with names of other practitioners if requested.

If I fail to cancel a scheduled appointment at least 24 hours in advance, I understand that an *automatic* charge of the full session fee will be made for the missed appointment and added to my fee during the next scheduled session. I understand that I will be responsible for this fee as insurance does not pay for missed appointments. You can call me at 704-705-4550 to notify me or leave a message as well as via email at dianeyee4@gmail.com. If I fail to attend two consecutively scheduled sessions without notifying Ashleigh, she may assume that I wish to terminate services. I also

understand that two consecutively cancelled sessions without prior notice may result in loss of an established appointment time. I also understand that I may terminate services at any time by notifying Diane Yee, MS, LPC.

If for any reason I am subpoenaed to testify in court on your behalf or regarding your case my fee is $150.00 per hour. This includes travel and waiting time as well as preparation time. I require a $500.00 retainer fee in advance. You will be responsible for payment of this fee in full.

I agree to the terms of the counseling and fee agreement as stated above and understand the above requirements. I release Diane Yee, MS, LPC from liability.

_____
Client Name (Printed)

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date