Heartstrings Counseling PLLC
Nina Danhorn, M.S., LPC, NCC
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720-924-1595 heartstringscounseling.com

Informed Consent and Financial Agreement

Appointments:
Services are provided on an appointment basis only. Please be sure to arrive on time for your appointment. If you arrive later than 15 minutes after the start of your scheduled appointment, your appointment will need to be rescheduled and you will be charged a late cancellation fee for this appointment. Twenty-four hour notification of appointment cancellation is required. Please be sure to provide a full 24-hour notice for cancellations or a fee of $120 will be charged to you. This fee is not paid by insurance companies.

Phone calls:
There is no charge for phone calls or text messages under 10 minutes as these calls are generally routine calls (i.e. appointments). Telephone conversations lasting over 10 min., site visits, report writing and reading, consultation with other professionals/family members, etc., release of information, reading records, longer sessions, travel time, etc. will be charged at the same rate in 15 min. increments at $25 for every 15 min. spent, unless indicated and agreed upon otherwise. Insurance does not usually reimburse for the aforementioned services.

Environmental Interventions:
These are services that are provided out of the office, which include but are not limited to school observations, meetings with other professionals on the client's behalf, etc. The fee for these services is $140.00/hour (prorated at $35/ 15 minute increments). This also includes preparation and research time spent for the intervention as well as travel time for the therapist to arrive at the location. This fee is not paid by insurance companies.

Billing:
Payment is due within 10 days of receipt of the statement and may be paid by cash, check or credit card. Billings generally reflect time spent- of any nature- on behalf of clients, usually in direct contact with clients. However, billing may also reflect time spent in collateral contact with others, including but not limited to, telephone conversations, phone consultations, reports, etc. A **$25** administrative fee may apply to any balances extending beyond 30 days.

Fees:
Initial Evaluation $140 (50-60 minute session)
Individual Therapy/Consultation $140 (50-60 minute session)
Couples Therapy $140 (50-60 minute session)
Family Therapy $140 (50-60 minute session)
Late Cancellation Fee $120 (less than 24 hours)
Other clinical Services, which include, but are not limited to emails, phone calls, letters, crises intervention, consultation, preparation or clinical records and therapeutic documents: $140/hour (charged in 15 min increments)
Mileage: $.75/mile
Copy of Record(s): $.25/page plus $10 processing fee
Court Testimony: $420/hour – including time spent waiting to testify

I, _____ (Last Name, First Name) agree to pay for psychotherapy services and other clinical services provided by Nina Danhorn MS LPC NCC, Heartstrings Counseling PLLC according to this fee agreement.

_____ I agree to pay for each service(s) listed above, in full, at the time that the service is rendered. Fees may be adjusted by therapist. I understand this will be discussed with me first.

_____ I have read and understand the Billing Policy as stated in this form. In addition, I understand that I will be limited to pay by cash or credit card, if I have a returned check. Returned check or cancelled payment fee is $25 in addition to the balance owed to Heartstrings Counseling PLLC.

_____ I understand that Heartstrings Counseling, PLLC requests to keep a credit card on file in order to obtain any missed appointment fees or unpaid outstanding balances for other services rendered by Heartstrings Counseling PLLC. You may choose to use the card on file to pay for your sessions or present another form of payment at the time of service. Parties may keep two credit cards on file for the purpose of separate billing.

_____ I will inform the therapist immediately of any changes in my payment and billing information and/or my ability or willingness to pay.

_____ I understand that I will be charged a late cancellation fee for no-shows, showing up over 15 min late or cancellations occurring less than 24 hours prior to my scheduled appointment.

_____ I understand that services will be terminated if timely payment is not made as agreed to by this consent or if the client presents 5 cancellations within the treatment year.

_____ I understand that consent to assume financial responsibility for these services does not entitle the third-party payer access to confidential information unless agreed in writing otherwise by the .

_____ I am a self-pay client and authorize Nina Danhorn MS LPC NCC, operating under the business name of Heartstrings Counseling PLLC, to charge me for her services. I will request a bill which is suitable for my presenting to my insurance carrier for possible reimbursement if I see fit. Not all conditions are reimbursable and must be resolved directly between the client and insurance carrier.

By signing this agreement, I acknowledge that I have read and agree to the cancellation and billing policies of Heartstrings Counseling PLLC. I understand and agree to take responsibility for the financial obligation of the client indicated on this form. I confirm that I have been given a copy of the Informed Consent and Financial Agreement. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me.

Client Name (print)	Date	Signature
Party Responsible for Payment Name	Date	Signature
Psychotherapist	Date	Signature