FEE POLICY

The Christian Family Institute is a private group practice providing counseling and therapy services for growth and enrichment. Mental health professionals provide these services with the necessary qualifications in their respective areas of specialty.

The Institute is funded entirely by fees charged for services. CFI is not subsidized by governmental or private organizations. This policy is in harmony with the Biblical principle of a workman being worthy of his wage (Matthew 10:10). Further, if we really want to grow, we must be willing to invest in that growth (Matthew 6:21).

Our normal fee is $120.00-$150.00 per session, consisting of 45 to 50 minutes. Charges for testing and/or the writing of Reports will be discussed with you, if these services become necessary. Any fees incurred for written reports, extended consultation with other professionals or court related services must be paid in advance.

Methods of payment include cash, check, VISA, MasterCard, and Discover. Due to increase in banking charges, a charge of fifty dollars ($50.00) will be assessed for any check that is returned from our bank for any reason. In addition, CFI reserves the right to seek the assistance of the District Attorney Bogus Check Division to obtain payment.

______ **Full fees will be charged for appointments made and not canceled 24 hours in advance**. No fee will be charged if the appointment is canceled 24 hours or more in advance. Insurance companies DO NOT reimburse for missed appointments. Lengthy or repeated telephone calls will be considered as appointments and charged accordingly.

______ As is customary with most professionals today, fees are due at the time of service. Special arrangements may be made on an individual basis due to financial hardship. An interest fee of twenty-eight percent (28%) per annum will be assessed monthly of all outstanding balances which are 60 days past due. Treatment will not be provided to any patient whose balance exceeds $250 without a written and signed financial payment contract. *Any outstanding balance that is past due more than 120 days may be turned over for collection action unless an alternate payment agreement has been reached, which may include reporting to credit bureaus (which will adversely effect credit scores) or filing a claim in small claims court.*

INSURANCE:
Clients seeking reimbursement from their insurance company **must notify us in advance** and are responsible to take care of their fees as services are rendered. If you desire, our office will assist you in filing your insurance claim. However, clients are fully responsible for obtaining reimbursement from their insurance carrier. An itemized statement of services rendered by our office will be available to attach to your claim form provided by your insurance company.

CFI will file your claim if we have a contract with your insurance company. Written permission to file claims with and collect payment from the insurance company is necessary. Clients are responsible for any services, authorized or unauthorized by their insurance company, not covered by their insurance company. Any co-pay (if applicable) is due at the time of service. At times it may be necessary to release treatment information to your insurance company to receive payment or to continue the treatment process.

Understand that your insurance coverage is just that, YOUR insurance coverage. You pay them to insure your medical coverage. Insurance companies do not guarantee payment of claims to providers. It does not release you from any financial obligations for the services we rendered to you. Please understand that all responsibility for providing referrals and pre-authorizations is the client's.

If your insurance ever changes, you must furnish us with a copy of your insurance card prior to treatment. It is your responsibility to make sure we have correct information and any necessary referral prior to your first date of treatment. Otherwise, you will be held responsible for the balance. If we are unable to verify your coverage and/or obtain a proper referral, you will be held responsible for any balance.

I have read, understood, and agree to the policies stated above.
I also give consent to release information to my insurance company as stated above.

______________________________ Signature of Client or Responsible Party

______________________________ Signature of Client

______________________________ Date

Revised 4/1/2010