Into the Light
Mental Health and Consulting Services, Inc.
201 NW 4th St. Suite 105
Evansville, IN 47708
812-454-1564
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Financial Agreement

_____ *I understand that the standard fee for each intake is $275. The standard fee for individual sessions is $225 for one person. Sessions with more than one client present are charged $250 for each 50-minute appointment. Emergency appointments, which include nights and weekends, are scheduled at the rate of $275 for a 30-minute appointment.

_____ *I understand that this therapist does not "double bill," and the full cost of treatment is due at the beginning of the session, even if insurance is billed. Any payment from insurance will be reimbursed to me minus any copays or portion of the deductible.

_____ *I understand that I am responsible for all treatment fees/copays at each session. Failure to pay fees as outlined in my fee agreement will be viewed as failure to comply with program requirements and will result in termination of program services. This therapist will refer me to the local mental health agency for continued services with client permission. This therapist does not extend credit as this could constitute an unethical "debtor/creditor" dual relationship, and ultimately impact the therapeutic relationship.

_____ *I understand that I will not be charged for phone calls to schedule appointments with this therapist. Calls to doctors, schools, and other referrals will be billed to me at $50 per 15-minute increment.

_____ *I understand that reports provided to the courts, other therapists, attorneys, or any other report sources are billed at $250/hr. Please recognize the fact that report writing requires a review of all documents and the writing and dissemination of materials. Report fees are due prior to the release of the report.

_____ *I understand and agree to pay all costs of collections, including but not limited to collection agency fees, the collection agency's attorney fees related to this, and all court costs incurred by the collection agency for all accounts more than 30 days past due.

_____ *I understand that there is a $225 missed appointment fee for no show appointments, as well as appointments not cancelled within the 48-hour window of time. This fee must be paid prior to any future appointments and will be charged with the credit card on file with this therapist. Future appointments will be cancelled if this is not paid three days prior to the next scheduled appointment.

_____ *I am aware that I will be responsible for any and all attorney fees incurred by this therapist while working with me. All court testimony retainer fees must be paid in advance before this therapist will testify on behalf or in relation to me.

_____ *I understand that this therapist will provide phone consultation that is outside of the scope of traditional talk therapy. I am also aware that phone consultations are not 100% confidential or HIPAA compliant and are not covered by insurance.

_____ *I understand that this therapist requires a subpoena to appear in court. This therapist will consult with my attorney and/or the attorney requesting representation about the court appearance so that the therapist's schedule can be cleared. This therapist will testify in Vanderburgh or Warrick County. Fees for 1/2 day are $1,500, and a full day is $3,000 plus mileage regardless of the amount of time the therapist testifies. Court fees outside of Vanderburgh or Warrick will be determined on a case-by-case basis.

_____ *I understand that court fees are due 1 week prior to the court date and is the responsibility of the party who is responsible for the subpoena. If court is cancelled or rescheduled less than 48 hours prior to the court appearance, then the fees are NON-REFUNDABLE, and an additional fee will be required for a future court date.

_____ *I understand that fees are reviewed each year and may increase periodically. A 30-day notice will be given prior to the increase. I have the right to terminate therapy if I am not able to continue with services.

Client Signature*: _____ Date*: _____