KINETIC OUTREACH & WELLNESS CENTER

Balancing the Whole Person

Client Financial Responsibility & Good Faith Estimate

Outpatient Therapy Services

Please read each statement carefully and review payment estimates before signing below.

- Your signature below indicates your understanding and compliance with providing a valid credit or debit card number for all associated fees during services.

- Your credit or debit card will be placed on file for the length of services. Following service discharge, all associated fees with your account must be paid in full within 60-days or will be sent to collections.

- Your signature indicates your understanding that your identified payment method (credit or debit card) will be charged a flat rate of $_____ per 'Late Cancel/No-Call-No-Show' appointments unless canceled within 48-hours of your appointment.

- Your signature below indicates you will solely be responsible for all service fees per self-pay rates. Your insurance will not be responsible for payment.Your current self-pay rate is set at $_____. Payment is due at time of each appointment.

Estimated Service Fees

Psychotherapy Evaluation/Intake: 90791	$125
Individual Psychotherapy 53-60 mins: 90837	$95
Individual Psychotherapy 38-52 mins: 90834	$75
Individual Psychotherapy 16-37 mins: 90832	$50
Family/Couples w/ Pt 26+mins : 90847	$95
Family/Couples w/o Pt 26+mins: 90846	$95
Group Therapy: 90853	$65+ Dependent upon group

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Crisis add-on	$15 per hour
Service Collaboration	$25 per 30 minutes
Correspondences (Emails, fax, letters, FMLA, etc)	$15
Legal Fees (i.e. court, subpoena compliance, all correspondences with lawyers)	$375 per hour

Client Name: _____ Date of Birth: _____
Phone Number: _____ Parent/Guardian:_____

- Please enter Payment information exactly as it appears on your credit/debit card.

Circle:: VISA/MASTERCARD AMEX OTHER

Cardholder Name: _____ Card Number: _____
Expiration: _____ CVV Number (3 digit numbers)_____
Billing Address: _____
Billing Zip Code: _____

_____
Client/Guardian Signature

_____
Date