DragonFly Counseling, LLC
5201 Johnson Drive, Ste: 305
Mission, Kansas 66205

CLIENT FEE FORM

Client Name: _____ **Client #:** _____

STATEMENT OF CHARGES: It is important that you understand the behavioral health services covered by your insurance policy. You can obtain this information by contacting your insurance company directly. Some services such as report writing, attendance at meetings and court testimony are not covered by insurance. Charges per service are listed below.

90791		Diagnostic Intake/Assessment		$125
90837		Individual Psychotherapy Session (53-60 minutes)		$120
90839		Individual Psychotherapy Session with crisis (60 minutes)		$195
90840		Crisis code add-on for each additional 30 minutes		$75
		No show fee (failure to cancel a missed appointment)		$75

All other fees will be discussed on an individual basis as needed.

INSURANCE INFORMATION

Insurance Company: _____ **Policy #:** _____ **Group #:** _____

Policy Holder: _____ **DOB:** _____ **SSN #:** _____

Employer: _____ **Relationship to Client:** _____

Contact information for policy holder *(only if different from client)***:**

Address: _____ **Phone:** _____

By signing you agree to each of the following conditions:

1. The client or guardian of the client is responsible for payment of fees for professional services provided by Deanna L Gonzales, LSCSW. Payment is due at the time of service.
2. If the client is covered by an insurance policy and I agree to bill that company for services rendered, you are responsible for completing any required preauthorization and coordination of benefits forms and for all applicable co-pays, deductibles, coinsurance, and non-allowable charges. If your insurance company denies payment for services rendered, I will notify you in writing and require payment of all sums due. In most cases, a mental health diagnosis must be provided to your insurance company for reimbursement. If your contract with an insurance company requires that I provide them with other information relevant to the services provided, I may be required to send copies of any records maintained here pertaining to your therapy sessions.
3. Co-pays are due at the time of service.
4. Medicaid clients may be liable for a client obligation under this program and will be required to pay this in full.

5. If the client or the service provided is not covered by insurance, Medicare or Medicaid, payment is due at the time of service. I accept cash and credit cards.
6. You agree to notify me of any changes in name, address, telephone number or insurance coverage.
7. A no show fee may be required prior to rescheduling if a missed appointment is not cancelled within twenty-four hours prior to the scheduled appointment time.
8. The client is not responsible for session fees while the client is utilizing the allotted sessions pre-authorized through an employer assistance program (EAP). Once all pre-authorized EAP sessions are utilized payment for session fees becomes the responsibility of the client or guardian of the client responsible for payment of fees for professional services provided by Deanna .L Gonzales, LSCSW.

Assignment of Insurance Benefits *(To be completed for insurance providers)*

By signing this document, I agree to allow Deanna L Gonzales, LSCSW to release all information necessary for filing insurance claims and collecting fees from my insurance company. I hereby authorize payment for services rendered from my insurance company directly to DragonFly Counseling LLC. Benefits otherwise payable to the client for treatment rendered by Deanna L. Gonzales, LSCSW will be paid to DragonFly Counseling LLC. upon receipt.

I have been given the opportunity to ask questions and agree with this fee contract.

I understand that I have the right to a copy of this document if I so desire.

☐ I have received a copy of this document.

☐ I have waived my right to receive a copy of this document.

_____ _____
Signature of Responsible Party *Date*

_____ _____
Signature of Witness *Date*

It is expressly understood that photocopies/fax of this form shall be as valid as the original.