E**nvisioning** H**ope** C**ounseling** S**ervices, LLC**

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1113 – B Hillcrest Parkway

Dublin, Georgia 31021

Phone: 478-353-1195

Phone: 478-246-7367

Email:*admin@envisioninghope.com*

Website: <https://envisioninghope.com/>

 **Counseling Financial Agreement**

**For Self-Pay Clients**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to pay Envisioning Hope Counseling Services, LLC Licensed Professional Counselor, Hope Fowler, LPC, NCC, CCMHC, CGP, CIMHP $250 for the initial intake visit and $150 an hour per face to face and/or Tele-mental health counseling session. The payment should be rendered upon my arrival for the session. As soon as insurance coverage is established and verified, the rates will change per hour, per session (subject to change based on insurance requirements).

**For Insured Clients**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to allow Envisioning Hope Counseling Services, LLC Licensed Professional Counselor, Hope Fowler, LPC, NCC, CCMHC, CGP, CIMHP to bill my insurance provider for payment for the initial intake visit and follow-up visits for face-to-face and/or Tele-mental health counseling services rendered. All co-payments should be rendered upon my arrival before services are rendered. Envisioning Hope Counseling Services LLC will provide you with your co-pay amount based on information obtained from your current insurance provider. My office will bill your insurance company for services provided. You are responsible for payment (and insurance claims) on your account. Failure to pay your part may jeopardize your benefits. Copays are not negotiable.

**For All Clients**

Late cancellation (less than 24 hours before) appointments are billed to the client in the amount of $50.00. No Show are billed to the client in the amount of $100.00. In the case of illness, please notify us no later than 9:00 a.m. the day of the appointment. Please leave a message if you get voice mail. If your appointment is cancelled or missed, contact the office for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations.

I agree to stay in contact with my Counselor concerning any changes to my insurance and/or payment method prior to service.

I reserve the right to terminate services at any time, and I will notify the Counselor at least a week in advance, prior to termination of services.

I have read, understand and agree to the above policies. I have been offered a copy of

these policies to take with me if desired. I hereby authorize (Envisioning Hope Counseling Services, LLC) and my therapist to release any information acquired in the course of my therapy to my insurance

company (if client is a minor, parent or guardian sign). I understand my insurance coverage is a relationship between me and my insurance company, and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with (Georgia) State Law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I have read and/or received a copy of (Envisioning Hope Counseling Services LLC)’s Privacy Policy.

Late Cancellation: $50.00

No Show: $100.00

Bounced Check Fee: $25.00

Signed this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_, 2022.

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Client

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Counselor/Envisioning Hope Counseling Services Representative