MN Mental Health Consulting

7600 Parklawn Avenue, #380
Edina MN 55435

Payment Contract for Services

Part One: Fees for Professional Services

I understand that the below fees are the reasonable and customary fees charged by MN Mental Health Consulting. **If for any reason my insurance company or EAP refuses payment I agree to pay MN Mental Health Consulting the following rates per session.**

A fee of $ 175.00 for an Intake/Assessment
A fee of $ 130.00 for Individual Therapy (up to a 45 minute session)
A fee of $ 170.00 for Individual Therapy (52+ minute session)
A fee of $ 150.00 for Family/Couples Therapy

Court testimony and reports required for legal proceeding must be discussed in advance and are billed at the full hourly fee, including transportation and wait time. The responsible party will be billed for this service even when the identified client may not have initiated the clinician's testimony.

Part Two: Insurance

MN Mental Health Consulting relies on accurate information from you to properly bill your insurance company for services. Please notify your clinician as soon as possible if your insurance information changes.

MN Mental Health Consulting charges estimated payments based on information from your insurance company.

Our clinic suggests you confirm these estimates with your insurance company. The Person Responsible for Payment of Account shall make payment for services that are not paid by your insurance policy; including all co-payments and deductibles.

Bill to: Client responsible for payment of account: _____

Address: _____City: _____ State: ___ Zip: _____

Client/Guardian Signature: _____ Date: ___/___/___

Release of Information Authorization to Third Party

I authorize MN Mental Health Consulting to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to my insurance company, _____, for the purpose of receiving payment directly to: MN Mental Health Consulting. I also understand that MN Mental Health Consulting employs a billing service and authorize disclosure of required information in order to determine coverage/benefits and to coordinate payment with my insurance company.

I understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I understand that I may revoke this consent at any time by providing written notice, and after one year this consent expires. I have been informed what information will be given, its purpose, and who will receive it. I certify that I have read and agree to the conditions and have received a copy of this form.

Client/Guardian: _____ Date: ___/___/___

Part Three: All Clients

Payments, co-payments, and deductible amounts are due at the time of service unless billing has been requested. The full session fee of **130.00** will be billed to clients who miss a scheduled appointment without calling to cancel with at least 24 hours notice. We appreciate your efforts in keeping your appointment or canceling within 24 hours so that we are able to offer this time to another client who may be waiting for an immediate appointment.

I authorize MN Mental Health Consulting to charge my credit card listed below for any balance applied to my account that is 90 or more days overdue. Any exceptions to this policy must be approved by the treating clinician.

Credit Card information:
( ) VISA ( ) Mastercard ( ) Discover

Cardholder Name:
_____

Credit Card #: _____

Expiration. Date: ____/_____V-Code (See below): _____
(V-Code: the last 3 digits in signature block on MasterCard & Visa)
X_____ ____/____/_____
Cardholder Signature Date