Helen Rudinsky, MS, LPC

Consent Form 2—Payment Contract

I , Helen Rudinsky, am committed to providing caring, professional care to my clients. As part of my services, I have established this **Payment Contract** to clarify payment for services.

Because outstanding balances require bookkeeping services and additional expenses, I have established a "**Pay as You Go**" policy and accruing a negative balance is not permitted.

I ask clients to become very familiar with these policies to avoid extra fees and expenses.

- I understand that payment is made before the session. I understand accruing a negative balance is not permitted.
- I understand the full, regular session fee is charged for missed appointments or cancellations with less than a 48 hour notice. This fee is to paid within 5 calendar days.
- I understand I am responsible to verify if counseling is included in my insurance plan. If my insurance does not pay my bill, I am responsible to pay my bill within 5 days.
- I understand that after I attend 4 counseling sessions I can request an Invoice or Summary of Services from the therapist to submit for reimbursement.
- I understand if I accrue a debt by not paying co-pays, session fees, and cancellation fees, my account will be forwarded to a Collection Agency. In addition to paying off my debt, I will be required to pay Collection Agency fees.
- If I am late for a session, I understand only the remaining time of my session will be used, no extension will be made. I am required to pay the full session fee.
- I understand I will be charged a pro-rated fee for the therapist to write letters, reports, handle disputes or consult with professionals (doctors, school personnel, etc).
- I understand that not abiding by this **Payment Contrac**t may be grounds for termination of services.

I HEREBY CERTIFY that I have read and agreed to the conditions of the **Payment Contract**.

Name (Printed)_____Date _____
Signature _____

Name (Printed)_____Date _____
Signature _____