Client Name:__________________ Date of Birth: _____________

Fee Agreement

Family Houston is a nonprofit organization supported by donations, private insurance, and grants. We are able to offer counseling services at the cost discussed with you at the time that you called to initiate services. Should there be any fee changes, we will provide due notice.

- Service fees are payable at the time services are rendered. If you cannot pay at that time, you will be offered an opportunity to reschedule your appointment.
- Non-payment of services exceeding $100 will cause your services to be put on hold until payment in full has been received.
- Family Houston does not extend personal credit. Payment must be made in the form of cash, personal checks, or credit cards (MasterCard or VISA).
- There is a $15.00 charge for every returned check. After two check returns, only cash or credit card payments will be accepted.
- **You will be responsible for a payment of $25.00 for appointments cancelled with less than 24 hours' notice, except in the case of emergencies. This is applicable to all clients except Medicaid clients.**
- You will be responsible for informing Family Houston of any changes to your insurance, Medicaid, or Medicare. If you fail to do so any charges incurred that are not covered will ultimately be your responsibility.
- If you have your therapist subpoenaed, you will be billed at the rate of $150.00 for each hour the therapist is required to be available. Such fees are payable at the time services are provided. Unpaid balances for these services must be paid before services can continue. There will be an additional document provided with more information if a clinician is subpoenaed.
- Other fees include but are not limited to: attendance or diagnosis letter ($30), emotional support animal letter ($50), immigration letter ($80), medical records (starting at $25).

Confidentiality

All services provided are confidential. The limits to confidentiality are listed below:

- If client discloses that a minor/child, elderly person or someone with disabilities is being abused or neglected
- If a client discusses threat to harm self or others
- If a judge subpoenas client's record

Should parent/guardian or client wish to share information with relevant parties (i.e. Psychiatrist, PCP, or school personnel) please authorize consent in the next section.

Consent for Treatment

I had been advised that I will be provided written descriptions of the program, my rights, and grievance procedures. I authorize the release of any information necessary to process claims to my insurance plan and/or to the insurance plan of individuals which I am legally responsible for. I authorize payment for services to be made directly to Family Houston, less any co-pays or deductibles for which I am responsible. By signing below, I give my consent for treatment within the Family Houston Counseling Program.

____ _____________________

Signature of Client or Parent/Guardian (if client is under 18) Date

Relationship to client: ______________________________

Coordination of Care

☐ **I DO or** ☐ **I DO NOT authorize Family Houston to release the information discussed during the course of my treatment to the practitioner/provider listed below. The reason for this disclosure is to facilitate continuity and coordination of treatment.**

Practitioner/Provider Name: ____

Address: ____

Phone: ____

____

Signature of Client or Parent/Guardian (if client is under 18) **Date**