FEE SCHEDULE AND OUT-OF-NETWORK VERIFICATION STATEMENT

I, ____, agree to pay for all services rendered, according to the following fee schedule. I understand that this schedule will go into effect on January 1, 2018:

- Diagnostic clinical evaluation (first session): $175
- 45-50 minute individual, couples or family therapy session: $145
- 55-60 minute individual, couples or family therapy session: $160
- 75-80 minute individual, couples or family therapy session: $190
- Records review, extended email contact, phone-based contact with clients between sessions, crisis management, consultation with other providers (as requested by the client), school-based observations, and other non-clinical services requested by the client: $45 per 15-minute increment.

I understand that the clinician, Leah Crowling, LMFT, is not in my insurance network and that I am responsible for payment of services provided on an out-of-network basis, at the time of services.

My signature on this form will represent the fact that I have read and understand that I am responsible for paying all fees for services, in accordance with the fees set in the Professional Service Agreement.

I understand that Chapel Hill Family Counseling will provide me with electronic statements that describe the nature and dates of clinical services rendered, the CPT codes for services renders, diagnostic codes, and fees for services rendered. I may submit these statements to my insurance carrier for purposes of seeking out-of-network reimbursement for any covered clinical services rendered. Provision of these monthly statements by Chapel Hill Family Counseling is a courtesy and shall not be construed as a guarantee of partial or full reimbursement by my insurance carrier.

____ Date:______________

Patient or Responsible Party's Signature

____ Date:______________

Therapist's Signature