Payment and Insurance Agreement

If you are paying for your services out-of-pocket, payment is due at the beginning of each session. Payment should be paid to me and not the receptionist. At this time, we do not take credit or debit cards, only cash or check.

If you have insurance, as a courtesy we will check with your insurance company to determine if I am a provider for that company and what your coverage is. In order to bill your insurance, I have to include a mental health diagnosis. This diagnosis once established will the part of your permanent record. There are also several circumstances in which you will have to pay, even if you have insurance. This includes if you have not yet met your deductible and/or you have a co-payment. You are responsible for filing claims with any secondary insurance company you have a policy with. If for any reason your insurance company does not pay, you will be responsible for the entire amount.

For missed appointments, a 24-hour notice of cancellation is required, except in the case of personal emergency. Otherwise, you will be charged 50% of the regular fee.

Fees

Initial intake or one-time consultation	$125
Individual, couples or family session (55 min)	90
Individual, couples or family session (25 min)	50
Group Therapy per session	50
Report Preparation and transmittal	Pro-rated hourly rate
Telephone and online consults (15 min+)	Pro-rated hourly rate
Court Appearances (including prep and travel)	$2,000 per day.

Contacting Me

In case of an emergency during office hours (9 a.m. – 5 p.m. Monday through Friday), you may call the office at 434 239-0003. If after hours, and it is an emergency, call 911 or the Mental Health Emergency Department at Lynchburg General at 434 200-3033. You can e-mail me. I do check my e-mail daily. However, do not e-mail in case of an emergency.

Consent to Psychotherapy

Your signature below indicates you have read this document and you agree to the terms. I further understand that failure to pay my bill will result in my case being turned over to collections and that my name and the fact that I am in counseling will be released to the collection agency. I understand that I will be responsible for any expenses incurred in the collection process as well as the balance of my bill.

_____ _____ _____

Printed name of client | Client Signature | Date

_____ _____ _____

Printed parent/guardian name | Parent/ Guardian signature | Date

_Jon Winder, MRC, LPC, LSATP_____ _____ _____

Therapist name | Therapist Signature | Date

Contact :

E-mail: jwindercounseling@gmail.com
Website: jonwindercounseling.com 4/1/18