Crossroads
COUNSELING CENTER

Name: _____
DOB: _____
MRN #: _____
MID/Ins #: _____
MID/Ins #: _____

Financial Agreement and Consent for Treatment

CONSENT FOR TREATMENT

_____ *(initial)* I hereby Authorize Crossroads Counseling Center to provide outpatient services to me/my child. I understand that specific services will be discussed with me by my therapist during the treatment planning process.

_____ *(initial)* I hereby agree to report difficulties with medication use to Crossroads Counseling Center. Physicians are not in the office on a daily basis. Refills are given at the time of contact with physicians. At least one week's notice for a refill is required.

_____ *(initial)* I hereby understand that if my child is under the age of 16, a parent/guardian must remain at the agency or speak to the child's therapist prior to leaving.

HIPAA PRIVACY PRACTICES

_____ *(initial)* I have read and received a copy of Crossroads Counseling Center's *Notice of Privacy Practices/Confidentiality Clients' Rights and Agency Policies,* and I agree to the terms within.

FEES

_____ *(initial)* All fees are the direct responsibility of the client/guarantor, during treatment and if services are required following termination of care. We file insurance claims and make every effort to seek reimbursement from insurance companies and Medicaid. However, any balance not covered by insurance will be billed directly to the client/guarantor. Crossroads fee schedule is included on the back of this page. The fee schedule is updated periodically. Updated copies of the schedule can be provided upon request.

_____ *(initial)* Services requested of and provided by our agency that are not covered by health insurance (see fee schedule) will be the financial responsibility of the guarantor. The fees are the financial responsibility of the client/guarantor regardless of therapist recommendation, testimony or a ruling of the court.

_____ *(initial)* Payment is due at the time of service. Balances remaining after 30 days following services will be referred to collections unless payment arrangements have been made.

_____ *(initial)* If there are multiple guarantors, a court order must be provided stating financial responsibility. If this is not provided, the financial responsibility is that of the party seeking treatment.

_____ *(initial)* The guarantor is responsible for notification if there is a change in insurance coverage. If there is a failure to notify, any fees incurred will be the responsibility of the guarantor.

_____ *(initial)* Our therapists are committed to providing appointments that are timely and as frequent as needed. There is a fee for broken appointments or appointments cancelled without 24 hours' notice. The charge is one half the fee for the missed session. Appointment availability and times may be limited; please speak to your therapist if there is a problem with scheduling. Standing appointments are not maintained if broken without notice.

I certify that I am legally authorized to provide consent for treatment for this client. I have read and understand that the above services, if requested by me or my representative, is my financial responsibility and I have been informed that these fees will be due at time of services rendered or prior to provision of service as indicated above. I have read Crossroads Counseling Center's policy on charges, insurance filing, payment expectations, cancellations, and missed appointments. I agree to and accept financial responsibility as guarantor for payment for services received. In the event I use insurance benefits to pay all or a portion of the charges, I hereby authorize the release of any medical information necessary to process insurance claims filed on my behalf. I authorize the release of information to my insurance company(s) by phone, mail, or electronic transmission. I authorize direct payment to my service provider.

_____ _____
Signature of Client or Legal Guardian Date

_____ _____
Print Name of Client or Legal Guardian Relationship to the Client

_____
Guarantor

Revised 10/15/26

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FEE SCHEDULE

The following services may be covered by your insurance:

Clinical and Psychiatric Intake/Assessment	$210.00 to $280.00 per hour
Psychiatric Sessions	$90.00 to $360.00 per session
Individual or Family Therapy	$80.00 to $175.00 per session
Group Therapy	$40.00 to $60.00 per group
Psychological Evaluations/Testing (including report)	$85.00 to $170.00 per unit*

The following are not covered by insurance:

Brief Case Summary or Support Letter (no more than two pages)	$60.00 to $90.00*
Court Report	$60.00 to $300.00 per hour*
Court Appearance	$150.00 to $300.00 per hour including travel
Record Copying	75¢ per page for the first 25 pages, 50¢ per page for pages 26-100, 25¢ for each page in excess of 100 pages Minimum $10 fee

Court testimony fees are not covered by health insurance and are the responsibility of the client/responsible party. A deposit for court ranging from $500 to $2000* will be required at the beginning of treatment if court testimony is needed. If court issues arise during the course of treatment and court testimony is needed a deposit for court will be required at or prior to the time of subpoena. If the therapist is not subpoenaed in your case the deposit for court will be refunded to you in full. If the therapist does testify in your case the deposit for court will be used toward expense for travel time, court preparation and courtroom/deposition testimony. This fee applies regardless of therapist recommendations, testimony, or ruling in the case.

* Therapist will give estimate prior to service provision.

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