



SANTA ROSA COUNSELING CENTER

5962 Berryhill Road, Milton, Florida 32570
Office (850) 626-7779 Fax (850) 626-7171
santarosacounselingcenter.com

K. Alesia Willis, LMFT, LMHC
Licensed Marriage and Family Therapist
Licensed Mental Health Counselor
Brian E. Willis, B.A.
Mental Health Counselor Student Intern
Melissa D. Willis, B.A.
Mental Health Counselor Student Intern

TERAPY AGREEMENT

I hereby grant my permission for any therapy that may be deemed pertinent by my clinician. I understand that my counseling sessions are strictly confidential; however, law mandates clinicians to honor court subpoenas. I understand that clinicians have an obligation to report knowledge of or instances of suspected child or elder abuse or neglect as mandated by Florida statute 415.504.

The rate for providing psychotherapy services is based upon a customary fee schedule:

I agree to pay the amount of \$120.00 for the first psychosocial assessment appointment and \$100.00 per session thereafter. I also understand that certain insurances are accepted and that information will be sent to my insurance company for payment of services if I choose this option.

Therapy sessions are approximately 50 minutes in length. Payment and/or copays are payable at the time of the services. I understand I must cancel my appointments 24 hours in advance.

I understand that the form of payment may be made in a check, cash, or credit card.

I learned about your services through (Check one):

- Yellow Pages The Talking Phonebook facebook
- PsychologyToday santarosacounselingcenter.com Other: _____
- Friend Internet Search

I have read, understand, and agree to the above policies.

Patient Name	Patient Signature	Date

Clinician	Credentials	Clinician Signature	Date



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CONTRACT AND FINANCIAL AGREEMENT

RIGHTS AND RISKS

Please feel free to ask questions about any aspect of the counseling process. You may remember unpleasant events, arouse intense emotions, and/or alter close relationships. If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report.

CONFIDENTIALITY

Information shared will be held in confidence. You may want to discuss further limits or exceptions of confidentiality. Information will not be released without your written consent. We are required by law to disclose information pertaining to suspected child abuse and threatened harm to oneself or others. In select cases, the courts may subpoena medical records.

APPOINTMENTS

Please be punctual. Sessions are approximately 50 minutes. Your appointment must be confirmed the day prior to the appointment by 4:30 PM or we reserve the right to reschedule your appointment. **No-show appointments and late cancellation/rescheduled appointments are billed to the patient at \$75.00.** In the case of an emergency, please notify the office no later than 8:30 AM the day of the appointment. Leave a message if you reach the answering service.

FEES

All copays are payable at the time of service. Insufficient Funds Fee: \$25.00

I have read, understand, and agree to the above policies.

Patient Name

Patient Signature

Date

Clinician

Credentials

Clinician Signature

Date

ACCOUNTS AND INSURANCE

MEDICAID PATIENTS ARE NOT REQUIRED TO COMPLETE THIS SECTION

To help you understand and anticipate any difficulties in insurance benefits that you may encounter, please review this section thoroughly.

DETERMINATION OF INSURANCE BENEFITS

When you become a patient at Santa Rosa Counseling Center, LLC, we contact your insurance company to obtain information regarding the coverage you have for mental health. We have developed a list of the questions that we ask so as to get a picture of the nature and extent of your coverage. If desired, we will provide you with a copy of this summary. Please review this information. If you think you have different coverage or a different level of benefits, please notify us so we may clarify the information. We suggest that you also call your insurance company directly for clarification. Unfortunately, this verbal verification of benefits does not oblige insurers to pay. Insurance companies protect themselves by stating that verbal verification of your insurance coverage by them is:

- not a guarantee of payment, and is
- not a guarantee of what is and what is not actually covered.

Because of this disclaimer, even when they have told you or us that a service is covered, there is no obligation for them to pay. The true determination as to whether a service is covered is made at the time the claim is received by the insurance company. Whether your insurance company will pay is dependent on whether:

- the service you received is covered by your plan,
- the reason for the service is covered by your plan, and
- the appropriate deductibles and co-pays have been met.

FILING OF CLAIMS

For Insurance Companies/Networks with Which We Are Contracted

We will routinely plan to file a claim for coverage of rendered services with your insurance company if you have insurance with a network with which we participate, if your plan provides benefits for the service provided for the reason it was provided, and if there are no other restrictions on covered services of which we are aware. At the time of your visit, we will collect any required co-payment, co-insurance or other fees noted as patient responsibilities.

If you have insurance with an insurer with which we participate, but your plan does not provide benefits for the services rendered, then full payment is required at each visit. It is our policy that all balances will be settled on the day service is rendered.

For Insurance Companies/Networks with Which We Are Not Contracted

If you have health insurance with an insurer with which we do not participate, then full payment for all services rendered is required at the time of your visit. As noted above, we require that each patient's balance be settled on the day it occurs. If requested, we will provide you with a statement that can be submitted as a claim to your insurance company for reimbursement directly to you.

Similarly, our audits may occasionally detect that services were incorrectly posted to your account, resulting in overcharges or undercharges. When we identify such errors, we will correct your account, resulting in a credit or a balance.

SETTLING OF BALANCES

As discussed above, there are times when insurance companies process a claim in a manner different than expected. In these cases:

- a claim may be completely denied as not covered, with no payment being made, thereby making you entirely responsible for the charge, or
- a claim may pay differently than was anticipated, also thereby making you responsible for a larger portion of the charge than expected.
- even though your insurance company communicated to us and we in turn communicated to you that a given service is covered, this IS NOT A GUARANTEE BY US of your insurance company's coverage for that service. If your insurance company denies coverage for any reason, you are responsible for full payment of the services billed. Because the insurance company states that the verbal information they provide is not a guarantee of payment nor can it be relied on as a guarantee of coverage, we are not bound by or responsible for any statement made by your insurance company, nor any statement made by us to you based on information given to us by your insurance company. It is very important for you to understand that the only TRUE representation of whether a given service is covered is when your insurance company actually processes the claim.

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CREDIT CARD AUTHORIZATIONS

It is our policy to require a credit card authorization be on file so that your balances can be settled as they occur. When credit card charges for unpaid balances arise, we will charge your credit card and mail to you a copy of your credit card receipt and your statement on the day the charge is made.

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INTEREST ON UNPAID BALANCES

If we are unable to charge your credit card account for an outstanding balance on your account that is your responsibility and that is greater than 30 days old, we will assess simple interest on the unpaid balance at the rate of 1.5% per month. This represents an annual interest rate of 18%.

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CREDIT CARD AUTHORIZATION

I give Santa Rosa Counseling Center, LLC authorization to keep credit card information on file and to charge the credit card account below for any outstanding balance on my/our account.

Type of card: (Check one)

- Visa
 MasterCard
 Discover

Credit card number

Name as it appears on card

Expiration date (mm/dd/yyyy)

Signature of Cardholder

Date

3 digit CVV/CVC number

This number is printed on your MasterCard & Visa cards in the signature area of the back of the card. It is the last 3 digits AFTER the credit card number in the signature area of the card.

PATIENT'S ATTESTATION

I fully understand the Accounts and Insurance described above for Santa Rosa Counseling Center, LLC. I understand that I am responsible for any balance not covered by or paid by insurance for any reason.

Patient Name

Patient Signature

Date