Powhatan Family Counseling
And Education Center
Dr. Judith Cain-Oliver, Licensed Clinical Psychologist
2156 Plainview Business Center Powhatan, VA 23139
(804) 598-9577 Fax (804) 598-0084

Financial and Practice Agreement

- If you are using your **health insurance**, you need to call the number on your insurance ID card and fill in the **Insurance Benefits Form**, included with the registration forms. When calling your insurance, you will be able to confirm that Dr. Cain-Oliver is covered by your insurance plan and obtain pre-authorization of services if necessary. You will also be informed if there is an annual **deductible** amount to be met or if you need to pay a **copayment** or **coinsurance**.
- **Payment** of the client's portion of the fees is due at the time of service. If the client is unsure of their financial responsibility according to their insurance plan, then a standard payment of **$60.00** is required at each visit.
- Payment may be made by cash, check or credit card
- There is a **$75.00** charge for **missed appointments** or appointments cancelled less than **48 hours in advance**. This charge is not covered by insurance policies.
- **Services not covered by health insurance** include, letter- and report writing, phone calls lasting more than 10 minutes, and authorized contact with other professionals, including attorneys, teachers, physicians and therapists. These services will be discussed with the client in advance, and are usually prorated based on the time involved, at an hourly rate of **$160.00**. Appearances in court are charged at the rate of **$300.00** per hour including travel time.
- **Cases involving court** may be subject to a retainer or case management fee. This will be discussed between the therapist and client.
- There is a **$35.00** charge for all **returned checks**.
- If your account is turned over to a collection agency, you will be responsible for all **collections costs up to 33%,** including court costs and filing fees.
- There is to be **no recording** of sessions without the written consent of all parties (clients and therapist).

I have read the above terms and accept treatment under them. Date: _____

_____ _____

Printed Name of Client Signature of person responsible for payment