The SUMMIT COUNSELING CENTER

POLICY AGREEMENT

Please carefully review the policies below, and initial.

INITIAL

_____ Once an appointment time is scheduled, we are committing to being available to you for that period of time. Please give us a 24-hour notice when cancelling or changing an appointment. The fee for a missed appointment without prior notice is the full session rate. Cancellations that are within the 24-hour window of an appointment (Late Cancellations) will be charged 50% of your session rate. Clients with $0 co-pay are responsible for a $60 cancellation fee for no-shows and a $30 fee for late cancellations. *

_____ I understand that The Summit Counseling Center does not participate in any insurance plans, nor do they file insurance claims on my behalf. However, I may be able to utilize my insurance company's "out-of-network" benefits. If I choose to do so, I am able to request a copy of my session's billing. I understand that if I choose to submit my expenses to my insurance company, any Client Assistance Funds received from The Summit may disqualify me from accessing Out of Network benefits, or reduce the amount my insurance company is required to cover.

_____ I understand that fees can be paid by cash, check or credit card and that payment is due at the time of service. There is a NSF/returned-check fee of $50.00.

_____ I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any direct services, products/materials, or court fees incurred. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, The Summit has the option of using all legal means to secure the payment. This may involve hiring a collection agency or going through small claims court.

_____ Should I become involved with legal proceedings that require the participation of my therapist, I will be expected to pay for our professional time even if called to testify by another party. The Summit will charge twice the private hourly rate for participation in any legal proceeding and billable time will include the time spent in travel.

_____ Proof of income is required for all applications for finance assistance, and for periodic renewal of client assistance. Failure to provide proof of income will result in my full responsibility for the private pay rate of therapy.

_____ In the event that I have accrued an outstanding balance of more than two sessions/co-pays, I will be referred to The Summit's financial counseling, where I will have the opportunity to clear my balance with the assistance of a payment plan. Should I fail to manage my balance without evidence of extenuating circumstances, I understand that I may be at risk of being referred to an external collection agency and will lose my ability to schedule further sessions until the balance is resolved.

_____ I agree to receive e-mail communication regarding billing communication, including statements and receipts.

Signature _____ **Date** _____

Client/Parent/Legal Guardian

**Does not apply for free/reduced lunch clients.*

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