Kelly M. Chadwick, LCSW, LLC
9157 Atlee Road, Suite A Mechanicsville, VA 23116
(804) 937-5344 | kelly@kellymchadwick.com

Financial Agreement and Credit Card Authorization Form

Fee Schedule

Initial Individual Therapy Evaluation – 60 minutes	$150
Individual Therapy Session – 50 minutes	$100
Initial Marital Therapy Evaluation – 1 hour 40 minutes	$200
Marital Therapy Session – 60 minutes	$135
Marital Therapy Session – 80 minutes	$170
Late Therapy Cancellation (less than 24 hours) / No Show Fee	$50
Court Appearance Retainer	$1,500
Court Appearance Fee/Depositions per hour	$200
Phone Consultation/Professional Fees per hour (prorated)	$100
Written Reports (Courts, Supervisors, etc.) per hour (prorated)	$150

Insurance Processing

In accordance with the services that will be provided by Kelly M. Chadwick, LCSW, LLC, I hereby agree and authorize my insurance company to pay this agency in full for services rendered in accordance with my medical benefits as agreed to in my insurance policy. I hereby authorize Kelly M. Chadwick, LCSW, LLC to release to my insurance company any information necessary for seeking reimbursement for the services listed below.

Name of Insurance Company: _____

Amount of Co-Payment: $ _____ as assigned by my insurance company.

Annual Deductible Amount: $ _____ as assigned by my insurance company.

Has your deductible been met? Yes No

Direct Rate: $ _____

Your insurance company may require that you pre-authorize your treatment with us prior to your visit. It is your responsibility to monitor insurance benefits, deductibles, as well as effective and termination dates of coverage. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have any questions, please contact your plan administrator. Feel free to speak with me if assistance is needed with this. By signing below, the undersigned affirms that he/she has read, understands and agrees to the finance agreement as outlined above. I authorize my insurance company to make payments directly to **Kelly M. Chadwick, LCSW, LLC** for services rendered.

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Insurance Authorization

1. A portion of these charges are generally reimbursed by insurance policies. Please note that some insurance companies **require authorization for services prior to the initial session**. Therefore, it is important for you to contact your insurance company to verify your benefits, determine any deductible and/or co-payment amounts that may apply and to obtain any required initial authorization for services. Kelly M. Chadwick, LCSW, LLC will bill most insurance companies as a courtesy to you.
2. If you do not cancel your appointment, you can be charged the full amount of your missed session. There will be a **$35 charge on returned checks**. These charges cannot be filed to insurance companies and therefore are your full responsibility
3. Payment is required at the time of service for the portion of your bill not covered by insurance. **Any and all charges not paid by your insurance company will become your full responsibility.** This includes any payment not received from your insurance company within 90 days from the date of the claim being submitted
4. I authorize Kelly M. Chadwick, LCSW, LLC to release to my mental health plan any and all information which it deems necessary to insure prompt payment of all charges for services provided. I also assign the payment of all insurance benefits directly to Kelly M. Chadwick, LCSW, LLC for any and all charges incurred in connection with services provided.

I am aware of scheduling policies; fees to be charged; policies regarding missed appointments; and if applicable, matters related to insurance.

_____

Printed Name (Authorizing Insurance Billing)

_____ _____

Signature **Date**

If you **do not wish to use your insurance** to cover and or reimburse you for the cost of psychotherapy services, please read, sign and date below:

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Decline Insurance

I hereby **do not authorize** Kelly M. Chadwick, LCSW, LLC to release to my insurance company any information necessary for seeking reimbursement for the services listed in this agreement. I acknowledge that **I am financially responsible for all payments according to the pay schedule in this document**. I agree to remit payment prior to starting each therapy session.

Self-Pay Printed Name (Decline Insurance)

Signature of Self-Pay Client **Date**

Credit Card Policy

My credit card policy enables you to maintain your credit card securely on file with Kelly M. Chadwick, LCSW, LLC. This is required even if you do not intend to use a credit card to make payments so that I may have a backup for any missed session fees, forgotten payments, etc.

In providing me with your credit card information, you are giving Kelly M. Chadwick, LCSW, LLC permission to automatically charge your credit card on file for your (or any other patient(s) you have listed on this form) co-pays/co-insurance, outstanding balances, services, and/or products.

- **Co-Pays/Co-Insurance:** Co-pays and co-insurances are due at the time of the office visit. You will make your payment each session by check, cash, or a card different from the credit card on file.
- **Outstanding Balance:** If your insurance provider has paid their portion of your bill (or any other patient(s) you have listed on this form) and there is still an outstanding balance owed, Kelly M. Chadwick, LCSW, LLC will notify you via phone and/or mail. If the balance remaining is not paid in full within 5 days of the notice, at that time, any balance owed will be charged to your credit card. A copy of the charge will be mailed to you upon request. This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. Missed appointment and other non-insurance-billable fees will be charged at the time of the missed appointment or fee assessment. A receipt can be provided upon request
- **Other Services and Fees:** Self Pay services, co-pays/co-insurances, no-show, late cancellation and other fees are due at the time of the office visit.
    - Contact outside of our scheduled sessions and non-face-to-face will be billed at my prorated regular hourly rate, this may include phone contact, voicemails, or reading and receiving emails in excess of 10 minutes per week, completing forms such as medical/ FMLA per your request, report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

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- A **$2.00 processing fee** for any charges that must be manually entered (not swiped). Checks that are returned will incur the check amount and an **additional $50 bank fee** or equal to what is charged to the Kelly M. Chadwick, LCSW, LLC business account by the financial institution for said returned check.
- A **missed session fee of $50** if the session is not attended, attended 15 minutes late, cancelled or rescheduled in less than 24 hours of scheduled appointment.

This card will only be authorized for the use of the credit card holder or any person(s) listed below by the credit card holder. This agreement will expire upon termination of services and settlement of final balance. The card holder may also revoke this consent at any time in writing while understanding that continued services may not be available if an unpaid balance accrues.

Charges will appear on your debit card statement as: **"Kelly M. Chadwick, LCSW, LLC"**.

Credit Card Type: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Card Number: _____

Exp. Date: _____ **Security Code (CVV):** _____ **Billing Zip:** _____

Name on Card: _____

Cardholder's Signature: _____ **Date:** _____

Please fill out the information below for any other person(s) you authorize this credit card for: If **NO OTHERS ALLOWED**, please strike through and initial:

Patient Full Name: _____ **DOB:** _____

Patient Full Name: _____ **DOB:** _____

Cardholder's Signature: _____ **Date:** _____

Please initial each of the following authorizing:

_____ **$50 missed session or cancellation fee** for less than 24 hours confirmed notice

_____ Balances **not paid within 5 days** of notice will be charged to credit card on file