Dawn Wilcox, LCSW
www.dawnwilcox.com

FINANCIAL AGREEMENT

Service	Fee
Initial Evaluation (90 mins)	$250
Individual Session (60 mins)	$165
Extended Individual Session (75-90 mins)	$250
Family/Sibling Session	$165
Parent Consultation (60 mins)	$165
Telehealth Session	$165

Miscellaneous Services:

Service	Fee
Letter Preparation	$150
Treatment Summary	$200

Cancellation Policy:

Your appointment time is reserved especially for you. If you are unable to keep your scheduled appointment time, a 24-hour notice of cancellation is required. Except where emergencies preclude a timely cancellation, the FULL fee will be charged for sessions missed without such notification. Most insurance companies will not reimburse for missed sessions. This charge is billed directly to the patient.

__________ (Initials) I understand the cancelation policy and understand that my credit card on file will be charged for missed appointments. I will be notified prior to being billed and may choose an alternate form of payment.

Terms and Conditions

- All payments are due at the time of each session unless other arrangements are made in advance.
- I understand that it is my own responsibility to be aware of my insurance benefits (e.g., out of network coverage, max benefits per year, deductible).
- I understand that a credit card is required to keep on file and I will be notified prior to the card being charged. I can choose a different form of payment at the time of service.

I understand and agree that Dawn Wilcox, LCSW is an “Out of Network” provider and I am responsible for submitting claims to my insurance company for reimbursement. Dawn Wilcox, LCSW will provide you with a claim form to submit to your insurance company if requested.

There will be a $35 service charge for all returned checks.

AUTHORIZATION FOR CREDIT CARD USE

I,_____________________________________, authorize Dawn Wilcox, LCSW, to charge my (or my child's) psychotherapy sessions to the credit card I have provided. I understand that this credit card will also be used to charge phone consultations, letters, treatment summaries and any other bills associated with Dawn Wilcox, LCSW (unless other arrangements are made).

Medical claim forms will be provided when requested.

This authorization will remain in effect until revoked in writing.

I have read and understand the payment policy and agree to abide by its guidelines.

Signature of Client/Parent/Guardian______________________________ Date________

A copy of this document was provided on ______________

Credit Card is required to be kept on file. You will be notified in advance prior to being billed for services.

Name ____

Billing Address ____

Cell phone ______________________________

Credit Card Number ________________________________

*Exp. Date*____________ *CVV* ____________

Client name (print) *Client Signature* *Date*