Jill Berlin, LCSW

FINANCIAL AGREEMENT

Initial Session (60 mins)	$180
Individual Session (45-60 mins)	$180
Extended Individual Session (75-90 mins)	$270
Family/Sibling Session (45-60 min)	$180
Parent Consultation (60 min)	$180

Miscellaneous Services:

Letter Preparation: $165
Treatment Summary: $200
Phone rates: Clients may request a phone conference or consultation. Fee for service can be inquired.

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 cancellation 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.
- A $10 surcharge will be added to fee if payment is not made when services are rendered.
- I understand that it is my own responsibility to be aware of my insurance benefits (e.g., max benefits per year, deductible).

I understand and agree that Jill Berlin, LCSW is an “Out of Network” provider and I am responsible for submitting claims to my insurance company for reimbursement. Jill Berlin, LCSW will provide you with a receipt at the conclusion of the session or if requested, at the end of the month. This statement will be mailed out to you the first week of the month for the prior month’s visits.

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

Should my unpaid account be assigned for legal collection, I understand that I will be responsible for all Interest accrual rate of 16% (per applicable NJ Law) and any other legal and debt fees incurred in relation to recovery of outstanding amount balances.

AUTHORIZATION FOR CREDIT CARD USE

I, _____, authorize Jill Berlin, 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 Jill Berlin, LCSW (unless other arrangements are made).

Medical claim forms or receipt will be provided at time of service.

Please advise Jill Berlin, LCSW if your credit card number changes so that there is no interruption in services.

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.

Credit Card that I wish to leave on file:

Name on Card _____ CVV _____

Address:

_____ _____ _____

Street City Zip

Card Number _____ Exp. Date _____