



## Evolve Counseling, LLC

Growth and insight through purpose-guided counseling  
227500 Rib Mountain Drive, Suite 101 - Wausau, WI 54401  
715-298-6201 [www.evolvecounselingllc.com](http://www.evolvecounselingllc.com)

### FINANCIAL AGREEMENT FOR SELF PAYING CLIENTS PSYCHOTHERAPY SERVICES

#### Cash paying clients:

Initial intake	1 hour	\$225.00 each
Subsequent Individual Visit	1 hour	\$180.00 each
Subsequent Individual Visit	45 min	\$160.00 each
Subsequent Individual Visit	30 min	\$135.00 each
Group therapy sessions	1 hour	\$75.00 per participant

#### I UNDERSTAND AND AGREE TO THE FOLLOWING:

- I understand that I am to pay all charges incurred.
- Your **ACCOUNT BALANCE** is due at the time of service. **If my account reaches a balance of \$200, my services can be suspended until the balance has been paid.**
- **CANCELLATION FEES:** Clients will be charged \$50.00 if an appointment is cancelled/not attended without a 24 business hour notice except in the case of an emergency.
- A **NON-SUFFICIENT FUNDS CHARGE** of \$35.00 per check will be charged for any checks returned to. These fees are not covered by insurance and need to be collected prior to subsequent visits.
- I will be billed at the hourly cash rate of \$100.00 for services that require a therapist's appearance, correspondence or phone calls related to legal, medical, educational or psychological assessments. Insurance does not cover these fees.

***My signature verifies that I understand agree to pay for charges incurred by myself and/or dependent. I agree to pay the portion not covered by my insurance company or EAP on the date that counseling services are rendered. I understand that this is a contract for services. I have read this information and I understand and agree to follow the policies listed above. I hereby authorize Evolve Counseling, LLC to bill my insurance carrier for the services that I and/or my family members receive. Evolve Counseling, LLC reserves the right to unsolicited discharge from treatment. I have read this information and I understand and agree to follow the policies listed above.***

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Client and/or Responsible Party)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Evolve Counseling, LLC Therapist)