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

FINANCIAL AGREEMENT FOR SELF PAYING CLIENTS

PSYCHOTHERAPY SERVICES

Cash paying clients:

Initial intake	1 hour	$200.00 each
Subsequent Individual Visit	1 hour	$150.00 each
Subsequent Individual Visit	45 min	$130.00 each
Subsequent Individual Visit	30 min	$110.00 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)