Kim Roser-Kedward, LCSW (LCS 22405)

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Fee Policy and Agreement

My practice is committed to providing the most effective mental health treatment and services possible. To do so, your understanding of the fee policy and the reasoning behind it, as well as your cooperation is needed.

Payment Schedule

Payment is due at the time services are rendered, unless other arrangements have been approved in advance. All applicable fees will be collected at the beginning of your session. By having you pay at each session, we eliminate the need to bill you. This helps keeps my costs as low as possible, prevents the accumulation of large debts on your part, and avoids possible risks to your privacy that occur when invoices for services are mailed to you. I encourage you to contact me immediately, if temporary financial problems affect the timely payment of your account.

Insurance Procedures

If you have medical insurance, I will do all I can to assist you in receiving your maximum allowable mental health benefits. This will require you to authorize me to provide your insurance company with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). When this occurs, I discuss the necessity of this with clients ahead of time. While it is presumed that the insurance company keeps this information confidential, I have no control over what they do with it once it is in their possession. Although I do not bill insurance companies for which I am not a network provider, I will be happy to provide you with an itemized receipt of your paid services including appropriate diagnosis codes. I will require your signed consent permitting me to provide confidential information to you and your insurer. Insurance claims are submitted electronically via a secured internet connection.

My fees are considered usual, customary, and reasonable by most insurance companies. However, some insurance companies reimburse on a rate “schedule” that is below the current standard. Depending on your insurance plan, you may be required to pay out of pocket the difference between our charges and their reimbursement. I must emphasize that my relationship is with you and not with your insurance company, and all charges are your responsibility from the date the service is rendered.

HMOs and Managed Care Provider Networks

I belong to the following HMOs and managed care provider networks: *Aetna, Blue Shield, Medicare, Mental Health Network (MHN), TriCare/TriWest.* These third-party payer systems may require a preauthorization for services and a co-payment at each session (except for Veterans Choice). Under no circumstances can the co-payment be waived, and it must be paid at the time of service. However, the co-payment is your only out-of-pocket expense (unless you have a deductible), and my remaining reimbursement is directly from the third-party payer (insurance company). Under this system, I accept the co-pay and managed care company reimbursement as full payment for the service provided to you. In this instance, my relationship is with the managed care company or provider network as well as with you.

These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some clients feel that they need for services after insurance benefits end. If this occurs, we will review your options for continuing to receive services.

Please be advised that it is your responsibility to notify me of changes to your insurance coverage and/or co-pays that occur during your annual, employer-sponsored, Open Enrollment.

Signature____ **Date**__________________________

Services Not Covered By Insurance
Regardless of the nature of your third-party payer, some of the services you choose to receive may not be covered under your mental health benefit (such as report writing, phone sessions or telephonic crisis intervention). Responsibility for payment for those services rests with you. *However, non-reimbursable services will be thoroughly discussed with you before they are provided, and you will have full opportunity to refuse such services and to consider alternatives.*

Payment Methods
It is the policy of this office to receive payment at the time services are provided.

- Payment will be collected at the beginning of each session. ________**(Initial Here)**
- Square is used to accept credit or debit card payments via a secured internet connection.
    - You will receive your credit card receipt via e-mail from Square.
    - If you have concerns regarding privacy, please be aware that the receipt will list my name and license. ________**(Initial Here)**
- Cash (*in the exact amount*) or checks payable to Kim Roser-Kedward, LCSW are acceptable.
- There is a $30 service charge on returned checks. ________**(Initial Here)**

Fee Schedule
My current fee is $175 for the initial assessment and $150.00 for 45-minute sessions. In addition to regularly scheduled appointments, it is my practice to charge $150.00 per hour on a prorated basis for other professional services *you may request of me*, such as telephone sessions/conversations (other than scheduling), report writing, or requested consultations with other professionals. Although this occurs infrequently (every few years), I reserve the right to periodically increase fees and generally give 3-6 months written notice to you.

If a situation requires a telephone consultation that exceeds 5 minutes, there will be a charge for each 15-minute segment, or portion thereof. Brief telephone calls in which you advise me of a schedule change or ask for a specific piece of information are encouraged. If the duration of the call is less than five minutes, you will not be charged.

If at your request and with your permission, I contact other people on your behalf—such as family members, teachers, or other health care professionals—and consult with them in person or by telephone, then the above fees for scheduled in-office and telephone contacts will apply.

If you become involved in a legal matter that requires my participation, you will be expected to pay for the professional time, preparation and attendance required, even if I am compelled to testify by another party. The professional fees for these services will be determined at such time.

Cancelling Appointments & Charges for Late-Cancelled Appointments
When an appointment is made, that time is reserved exclusively for you. I require a *minimum* of 24-hour advance notification if you are not able to keep a scheduled appointment. Having this notice permits me to offer that appointment time to someone else. If you have given 24-hour notice, you will not be charged for the appointment. However, if you break your appointment and do not call this office with 24-hour notice, you will be charged a fee for the session.

Signature____Date________________________

Charges for Late-Cancelled Appointments (continued)

Charges for broken appointments and appointments cancelled without 24-hour notice cannot be billed to your third-party payer (insurance company). You will be responsible to pay the late cancellation fee.

- A charge of 50% of the full session fee or the managed-care rate (not just the co-pay for managed care participants) is made for appointments cancelled without 24-hour notice. _____ **(Initial here)**

- If you miss the appointment without calling to cancel ahead of time (i.e. "no show"), the full session fee or managed care rate is due. _____ **(Initial here)**

Either of these charges are payable at the next session.

Arriving to Your Appointment Late

Being late to appointments impacts your care and our ability to help you make progress in therapy. Please call me to let me know that you are running late and when you expect to arrive.

- Please be aware that if you are late for your appointment, *I am unable to bill your insurance company for the full-session time that was reserved for you.* _____ **(Initial here)**

- A minimum of 20 minutes must be remaining in our session time, in order for me to be able to bill your insurance company for a portion of the therapy session. _____ **(Initial here)**

- You will be seen for the balance of your scheduled time, but you will be charged for portion that cannot be billed to your insurance company. _____ **(Initial here)**

- If you are more than 15 minutes late to your appointment and do not call me ahead of time to let me know that you are running late, I may consider that you have no-showed for your appointment time and the no-show fee may become due. _____ **(Initial here)**

As with any issue that may present itself, you should feel free to discuss with me any questions that arise regarding fee policies. I understand that there are times when difficulty with finances may temporarily prevent you from meeting your obligation under this contract. Should such a circumstance present itself, please contact me as soon as possible.

FEE

By signing below I am indicating that I have read and understand the above statements on fees and payment policies. I have discussed these conditions with Kim Roser-Kedward, LCSW and have had the opportunity to ask questions. My questions have been answered to my satisfaction. I understand and agree to meet my financial responsibilities in receiving treatment and services in this practice setting. Additionally, I agree to indemnify and hold harmless this office regarding any claim made against unpaid fees and to pay any legal fees and costs incurred in collecting such fees.

I agree to:

- ❑ the assignment of my health insurance benefit to this provider. I understand this requires disclosing my mental health diagnosis. _______ **(Initial)**
- ❑ remit to Kim Roser-Kedward, LCSW a co-payment in the amount of $_______ at the beginning of each session in keeping with the policies of my health benefits with______________________________.
- ❑ **For Cash-Pay Clients:** remit to Kim Roser-Kedward, LCSW at the beginning of each session the agreed upon fee of $____________, which is based on a rate of $__150__ per treatment hour.
- ❑ **For Veterans Choice Participants:** allow my progress notes be electronically uploaded to TriWest and disseminated to VA Healthcare for to allow for claim and billing for services accessed through Veterans Choice. I understand that if I have a co-pay or share of cost for these services, I will be billed by VA Healthcare directly. _______ **(Initial)**

NAME________________________________**SIGNATURE**______________________________**DATE**_________

NAME OF WITNESS: **KIM ROSER-KEDWARD, LCSW** **SIGNATURE**______________________________________

DATE ____