EARLY CHILDHOOD *Wellness place*

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Fee Schedule and Scheduling Contract

_____ Co-payments and fees must be paid at the time of each session. Please feel free to discuss any questions or concerns you have regarding our fee agreement with me. **Sessions must be cancelled with 24-hour notice to my EMAIL ADDRESS above.** You will be charged **$75.** for missing a session, or canceling less than 24-hours in advance.
-- MEDICAID ONLY - Medicaid clients will only be allowed 3 missed appointments

Intake Appointment	**$175.**
Ongoing Therapy services	**$150. per therapeutic hour (45-50 minutes)**

Providing comprehensive service to you and your family is important to me, and sometimes requires work above and beyond the therapy hour. This could include phone calls or consultations with outside providers, letters written at your request, and court testimony. Fees for these services are listed below. Insurance typically does not cover these services.

Additional Services	Fees
School visits, attending meetings at your request (including travel)	**$150. per hour**
Legal work (including preparation and travel)	**$400. per hour**
Letter writing	**$150. per hour**

_____ ***Phone calls or e-mails requiring review or response taking 10 minutes or more will be billed as follows:***

Phone calls/emails (over 10 minutes)	**$150. per hour**

I, the undersigned, agree to a fee of _**$150.**_ per session, or if I am using my insurance, I agree to pay the co-pay / deductible outlined by my insurance carrier. Client fees not paid in a timely manner will be forwarded to collections, and I will be responsible for any collection fees incurred. Checks returned for insufficient funds will be charged a **$30.** processing fee. **If preauthorization is required by insurance, it is my responsibility to obtain this. Should my insurance company fail to pay for services, I will be responsible for fees incurred at the above rates.**

My signature below indicates my agreement to pay all fees as outlined by this contract.

_____ _____
Signature of client/parent/guarantor Date

_____ _____
Printed name of client/parent/guarantor Date

_____ Our practice is comprised entirely of children and recognizing scheduling during the school year is difficult, we ask every family that **50% of sessions are scheduled before 1PM** so that after-school/evening times are not monopolized & no family must pull their child out of school early (or leave work early) all the time. **I do not have availability for families to only come during the afternoon hours.** In my experience, schools and teachers are very understanding if they know that children are receiving therapy. **Thank you for your understanding**.