EARLY CHILDHOOD Wellness place

520 Zang Street Ste 212; Broomfield, CO 80021
Margaret Pollack, MA, LPCC, ATR-P
Email: Margaret@earlychildhoodwellnessplace.com
Therapist Direct Mobile: 720-340-8239

Fee Schedule

_______**(Initial)** 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 at any time. **Sessions must be canceled with 24-hour notice to your ECWP Providers Direct Email: Margaret@earlychildhoodwellnessplace.com or Call/Text Margaret's Google Voice # 720-340-8239**
You will be charged **$75** for missing a session, or canceling less than 24-hours in advance, regardless of reason.
****Insurance will NOT cover cancellation charges.** **Rescheduling a canceled session will NOT waive the late notice cancellation fee.

Initial Intake	$150
Therapy Session	$130
Additional Services	**Fees**
School visits, attending meetings at your request (including travel)	$130 per hour
Records review & Treatment Summary	$130 per hour (1hr Minimum)
Letter writing	$200 per hour
CADE Evaluation	$450 plus a Parent Only appointment to review $130
Legal Services	**Fees**
Records review & Treatment Summary	$150 per hour (1hr Minimum)
Letter writing	$200 per hour
Attorney, GAL, CFI or PRE contact	$300 per hour
Court testimony: includes court preparation, travel, wait time, testimony & depositions	$300 per hour

Following a Subpoena, and in order to participate in any legal proceeding, **Early Childhood Wellness Place** therapists require a retainer PRIOR to the commencement of any legal work.

_______***(Initial)* While there is no charge for phone calls or e-mails to check-in briefly or to discuss scheduling, 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)	$130 per hour

I, the undersigned, agree to a fee of _**$130.00**_ per session, or if I am using my insurance, I agree to pay the amount outlined by my insurance carrier (Copay/Deductible/Coinsurance). 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.**
Any outstanding balance over 30days will accrue 5% interest fee. An additional 5% will be added to the outstanding balance every 30days and if unpaid after 90days, the account will be sent to collections.

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**