Integrated Care Concepts and Consultation

615 Hope Road, Eatontown, NJ 07724

Phone: 732-389-0697 Fax: 732-389-0611

Payment Agreement for Services

I understand and agree that Integrated Care Concepts and Consultation LLC will be providing professional services and I agree to pay fee(s) of:

$200.00 _____ Per session for the Initial Evaluation Session
$150.00 _____ Per session for individual therapy in office
$250.00 _____ Per session for individual therapy in home/other location
$175.00 _____ Per session for family/marital therapy
$300.00 _____ Per session for family/marital therapy in home/other location
$50.00 _____ Per session for group therapy
$350.00 _____ Per session for Psychiatry Evaluation Session
$150.00 _____ Per session for Psychiatry Follow-up
10% of Session Fee _____ to process out of network claims on behalf of client
$30.00 returned check fee
Appointments cancelled with less than 24 hours notice will be charged at session rate

I agree that I am responsible for the charges for services provided by Integrated Care Concepts and Consultation LLC therapists to me. Although other insurance carriers may make payments on my account, I understand insurance deductibles, co-payments, or full fee for services are due at day and time of services.

I further guarantee that charges for services provided will be paid upon receipt of billing statements from (this therapy/agency) and that the balance will be paid in full unless special arrangements are made for alternative payment scheduling. If such alternative arrangements are made, I guarantee that payment will be made in compliance with those arrangements.

I understand should I not fulfill paying my balance on account, that this balance will be turned over to a collection agency and may affect my credit.

I understand that this office will bill insurance companies and other third party payers, but cannot guarantee such benefits, and is not responsible for collection of such payments.

I agree that if I do not provide Integrated Care Concepts and Consultation LLC with notice of cancelling and appointment 24 hours in advance of the scheduled appointment that I am responsible for the payment of that appointment at the posted rate above. I will provide a credit card impression so the credit card can be charged for this and collection fees.

I have read the client's right form and reviewed the fee schedule. In signing this form, I understand my rights as a client and my responsibilities for payment to Integrated Care Concepts and Consultation LLC.

Credit Card Information

Please note we keep a credit card on file for no shows or for default in payment.
Credit Card Type: _____ Credit Card Code: _____
Credit Card Number: _____ Exp. Date: _____
Credit Card Name as it appears: _____

Client/Guardian Name:	Signature:
Date:	

Therapist Name:	Signature:
Date:	