Celeste Ryane, LCSW
Fee Agreement

The standard fees at Celeste Ryane's office are listed below. These fees can be paid in a variety of ways. The provider accepts certain insurance, and patients with insurance coverage are expected to pay their co-pay or co-insurance payment to the provider prior to each visit, as well as all fees not covered unless other arrangements are made prior to this time. If your copay, coinsurance and associated fees are not paid at time of service, an additional billing fee may be imposed. Your insurance contract is between you and your insurance company and you are responsible for knowing terms and exclusions to the policy that will ensure your insurance carrier's cooperation with us. If no insurance payment has been received within 60 days of billing, you will be responsible to pay the unpaid balance on your account.

I agree to the following arrangement for payment of fees:

- ☐ 1st Session – Intake/Assessment $250
- ☐ Cash Fee – Patient Pays 100% $200
- ☐ Follow Up Session –30 Min: $150
- ☐ Follow Up Session-60 Min: $220

Initial each line that you, the patient or guarantor, consent to this fee agreement:

_____ I have read the above information.

_____ I consent to being treated by Celeste Ryane

_____ I agree to pay the contracted fee at the time of service (unless other arrangements are made prior).

_____ I understand I will be responsible for paying missed sessions for which a 24-hour prior notice is not given, and my insurance company cannot be billed.

_____ I am fully responsible for all fees assessed to my account.

_____ If my insurance policy or another third-party coverage does not pay my doctor for the services rendered, I am responsible for paying the full amount of the fee (unless otherwise prohibited by insurance company regulations communicated to Celeste Ryane's office as part of the authorization process).

_____ Celeste Ryane has a legal right to utilize a collection or billing service to collect payment if I fail to pay in full for services received, and to refuse services until account is current.

_____ I have read and understand the conditions upon which my fee has been determined, and I agree to these conditions.

_____

Patient Name (Print) **Patient Signature(if under 18/see Guarantor)** **Date**

_____

Guarantor (Print) **Guarantor Signature** **Date**

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Guarantor: Phone # **Address** **City** **State** **Zip** **Relationship to patient**