Brooke LaChnace, MA, LPCA, NCC
Pathways to Growth Counseling
5200 Park Road Suite 236 Charlotte, NC 28209
704-612-4148

CLIENT CONSENT FOR TREATMENT AND BILLING AGREEMENT

I hereby give Brooke LaChance, LPCA, NCC, through Pathways to Growth Counseling to provide counseling services to:

_____ _____
Client Name Date of Birth

I understand that Brooke LaChance, LPCA, NCC, will provide the following service(s) to me for the indicated fees:

Cost of Treatment:

Intake/Initial Session	$125	Phone Consultation (per hour)	$100
Individual Therapy	$100	Credit Card fee	$3
Marriage/Couples/family	$115		

I understand that payment for services are expected at the conclusion of each session unless previous arrangements have been made (as indicated below) and agreed upon with Brooke LaChance, LPCA, NCC. If insurance arrangements have been made prior to the session and a co-pay is applicable, it is due at the time of my session. If for any reason your insurance does not agree to pay your fee (co-pay or percentage), you are ultimately responsible for payment in full.

In order to guarantee payment a credit card must be put on file and will be billed only with notice by Brooke LaChance for a missed or unpaid appointment.

Credit Card #_____ **Exp.**_____**Security Code**:_____

Name as it appears on card_____

Billing Address Zip Code_____ **VISA** **MASTERCARD**

Your insurance company has informed me that your benefits are as follows:

Insurance Company:_____**Deductible:**_____ **Co-pay:** _____

Max. # of sessions/Amount_____ **Per Calendar Year/Benefit Period:**_____

I agree to allow Brooke LaChance, LPCA, NCC, to bill my insurance company directly for service provided and understand that the insurance company may request information in order to process payment. I give her permission to release the necessary and requested information to the insurance company.

If payment is not made at the time of my appointment and it is not a matter of special arrangement agreed upon by myself and Brooke LaChance, LPCA, NCC, payment must be made within 7 working days of the session in question AND before a new appointment can be scheduled. If payment is not made within this time period, Brooke LaChance, LPCA, NCC has the option of informing me, in writing, that future services might be jeopardized and even discontinued. I understand that she can provide me with names of other practitioners if requested.

If I fail to cancel a scheduled appointment at least 24 hours in advance, I understand that an ***automatic*** charge of the full session fee will be made for the missed appointment and added to my fee during the next scheduled session. If I fail to make payment within 7 days of the missed appointment, I understand that the fee will be charged to the credit card number provided. I understand that I will be responsible for this fee as insurance does not pay for missed appointments. You can call me at 716-343-4135 to notify me or leave a message. If I fail to attend two consecutively scheduled sessions without notifying Brooke, she may assume that I wish to terminate services and she will notify me, in writing, that services have been terminated. I also understand that two consecutively cancelled sessions without prior notice may result in loss of an established appointment time. I also understand that I may terminate services at any time by notifying Brooke LaChance, LPCA, NCC.

If for any reason I am requested to testify in court regarding your case my fee is $500.00/hour. This includes travel and waiting time. I require a $1000.00 retainer fee in advance. You will be responsible for payment of this fee in full. I will also no longer be able to see you or your partner, as testifying in court breaches the client/therapist relationship.

_____
Client Name (Printed)

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date