Jacqueline Shea Vance, LCSW

Billing/Fees Policy

I, as the client and/or the parent/legal guardian of the client, am fully responsible for all payments to Jacqueline Vance for evaluations, assessments and therapeutic services. Ms. Vance's standard fee is $150.00 for the first 60 minute clinical assessment and $125.00 for a 50 minute therapy session. **I understand that I will be expected to pay the full fee for each session at the beginning of each session. I further understand that I will be charged $50 for any missed sessions not cancelled with at least 24 business hours notice. If I accrue an outstanding balance, the credit card on file will be charged the balance.** By request, Ms. Vance will supply a monthly "superbill" to submit to my insurance carrier for out of network reimbursement.

Ms. Vance does accept some insurance plans. Health insurance is a contract between you and your insurance company. **Clients who carry insurance are responsible for a copay and for obtaining authorizations required for treatment**. **Be aware that submitting a mental health claim to your insurance carrier for reimbursement carries a certain amount of risk. Not all issues/conditions/problems which are the focus of psychotherapy are reimbursed by insurance companies; it is your responsibility to *verify* the specifics of your coverage.**

Insurance Information:

I have submitted a copy of the front AND back of my insurance card.

Insurance Company:

Group/Employer Name/Effective Date:

____ I am the policyholder.

____ I am not the policyholder (Complete the information below).

Name:

Relationship to Client:

Date of Birth:

Home Address, City, State, Zip:

_____ I authorize payment of insurance benefits to my provider for all services provided.

____ I authorize the release of medical/psychiatric information to my insurance company and/or doctor or therapist.

I understand and agree to all of the above information.

Please complete your VISA, MASTERCARD, AMEX, OR DISCOVER credit card information below. This information will be used to pay for any sessions not paid for via check or cash at the time of service.

(PLEASE PRINT)

Name on card: _____

Card Number: _____

CVV Code: _____

Expiration Date: _____

Billing Zip Code of Card: _____

I authorize Jacqueline Shea Vance to charge the credit card listed above for all evaluation, assessment, or therapy fees.

_____

Authorized Cardholder Signature and Date