Counseling Services of Portland

7100 SW Hampton #128, Tigard OR 97223 503-342-2510

www.counseling-portlandoregon.com gethelp@counseling-pdx.com

Addendum Agreement for Group Therapy

Payments & Insurance Reimbursement*:** It is preferred that you **pay monthly in advance** for your group therapy sessions. If you cannot do so, **please be ready to pay at the *beginning of each group session. **Checks can be made out to your counselor**. You can pay by check, credit card or cash.

Your weekly fee for counseling is **$** _____ **per** _____ **- minute session.**

Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, etc., will be charged at a prorated rate of $120 per 50-minutes, unless indicated and agreed upon otherwise.

Please **notify your CSP counselor if any problems arise regarding your ability to make timely payments.**

As a courtesy to you, CSP will bill your insurance company for you. However, our services are provided and charged to you and not the insurance company, and you are ultimately responsible for payment.

As was indicated in the section *Health Insurance & Confidentiality of Records,* please be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. **Not all issues, conditions and problems which are dealt with in psychotherapy are reimbursed by insurance companies**. It is your responsibility to verify the specifics of your group counseling coverage.

Cancellation: Because other **group members are counting on your presence in group,** it is very important that you **attend group therapy regularly. Please let your fellow group members and counselor know during your group session if you'll be on vacation or missing a group.** We require at **least 24 hours notice to avoid the late cancelation fee. The full fee, not just your copayment, will be charged to you** for sessions missed without 24 hours notice. Most insurance companies do not reimburse for missed sessions.

I understand that **I am responsible for paying fees** incurred from **late cancellations without 24 hour notice**. My insurance will not cover missed appointments. I understand that I am responsible for the full fee of $ _____ which is not covered by insurance. Exceptions to this policy are cases where sudden illness and legitimate emergencies occur. I authorize my credit card to be charged at the time of the canceled session using the credit or debit card number provided in my intake.

_____

Client name (print) Date Signature

_____

Counseling Services s of Portland Counselor Date Signature