

# Genesis Counseling Services, Ltd.

One South Main St. \* P.O. Box 8010 \* Janesville, WI 53547-8010 \* 608-757-0404 \* Fax 608-757-2319  
www.genesiscounselingservices.com

## Fee for Service Contract

### Financial Policy:

The client/legal representative is responsible for payment of all fees for services provided according to the following fee structure:

	<b>1 ½ Hour</b>	<b>1 Hour</b>	<b>½ Hour</b>	<b>¼ Hour</b>
<b>Psychiatrist / Nurse Prescriber:</b>	\$400.00	\$300.00	\$200.00	\$100.00
<b>Psychologist:</b>	<b>1 Hour</b>	\$150.00		
<b>Masters Level Therapist:</b>		\$130.00		
<b>Groups:</b>		\$60.00		

Clients are billed according to the above stated fee structure. There is an additional \$10.00 charge for the intake assessment, which is the first session. **Uninsured, under-insured, high-deductible and HMO-restricted clients are eligible for discounted fees.** If you meet one of these criteria, please tell our office staff previous to or at the time of your first appointment, and you will be provided a private pay contract. Private payments are expected at the time the client checks in for their appointment.

### Insurance:

As a service to our clients, claims will be filed with your insurance company at no charge. If you have a deductible or if your insurance pays only a portion of the total fee, you are responsible for the balance. Genesis cannot accept responsibility for collecting from your insurance or for negotiating a settlement on a disputed claim. Payment on the balance will be expected within 30 days, or arrangements must be made for monthly payment toward the balance. It is up to the client or legal representative to make such arrangements.

### Payment of Fees:

Co-payment fees are due at the time of service. Other charges are to be paid upon receipt of your bill. If payments are not made in a timely fashion, Genesis reserves the right to seek legal means to secure reimbursement. For your convenience, we will send you a monthly statement regarding charges for services rendered by Genesis. If you note any discrepancies on that statement, please immediately contact our business office at 608-757-0404.

### Minor Children:

The parent or legal representative, who brings a minor child to Genesis and signs at the bottom of this form, will be held responsible for any part of the bill not paid by insurance. As a service to you, we will file a claim with any insurance company on which the minor is covered.

### Cancellations:

**If you need to cancel your appointment, you must do so at least 24 hours in advance.** This will allow us to fill that appointment time. If we are not notified, you will be charged \$50.00 for that hour. We know that there are emergencies due to circumstances beyond your control. If this happens, please notify us as soon as possible.

**I understand and agree to pay for services provided according to the above fee structure. I authorize payment of medical benefits, as described on the insurance form, directly to Genesis Counseling Services. I understand that this will include a diagnosis.**

---

Client/Representative Signature / Date

---

Office Staff Signature / Date