synchronicity COUNSELING Nichole Jordan, M. Coun., LCPC, NCC

Payment Contract for Services

Name(s): _____

Address: _____

City: _____State: _____Zip: _____ Phone:_____

Bill to:
Person responsible for payment of account:_____

Address: _____

City: _____State: _____Zip: _____ Phone:_____

Employer:_____ Phone:_____

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES

PART ONE FEES FOR PROFESSIONAL SERVICES

I (we) agree to pay **Nichole Jordan, M.Coun, LCPC, NCC** , hereafter referred to as the provider, a rate of **$85.00** for individual counseling and **$95** for relationship or family counseling for a standard 50 minute session, and **$120** for individual and **$130** for relationship and family counseling for an 80 minute session. The fee for an initial diagnostic interview is **$130**.

Payment is expected at time of service

A fee of **$45.00** is charged for missed appointments or cancellations with less that 24 hours' notice.

Additional fees may be charged for services not covered by insurance, such as extra report writing time, and any other services not covered by insurance. Any additional recommendation letters or development of treatment documentation requested by client beyond what is required for insurance billing will result in additional charges based on hourly fee.

A small portion of Nichole Jordan's appointments may be reserved for individuals requiring sliding scale fees based on individual financial circumstances per the established charity policy.

PART TWO CLIENTS WITH INSURANCE (DEDUCTIBLE AND CO-PAYMENT AGREEMENT)

Nichole Jordan is an approved provider for most insurance companies and will bill insurance directly for clients with health benefits. The following information provided by either you or your insurance company regarding your policy containing (but not limited to) the following provisions for mental health services:

ESTIMATED INSURANCE BENEFITS:

1) $ _____ Deductible amount (paid by insured party)
2) Co-payment _____ % ($ _____/clinical unit) for first _____ visits.
3) Co-payment _____ % ($ _____ /clinical unit) up to _____ visits.
4) The policy limit is _____ per year: _____ annual _____ calendar

We suggest you confirm these provisions with the insurance company. The Person Responsible for Payment of Account shall make payment for services that are not paid by your insurance policy, all co-payments, and deductibles. We will also attempt to verify these amounts with the insurance company.

Your insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

PART THREE ALL CLIENTS

Payments, co-payments, and deductible amounts are due at the time of service.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____

Date: _____/_____/_____

RELEASE OF INFORMATION AUTHORIZATION TO THIRD PARTY

I (we) authorize Nichole Jordan, M.Coun., LCPC, NCC to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above-listed third-party payer or insurance company for the purpose of receiving payment directly to Nichole Jordan, M.Coun., LCPC, NCC D.B.A. Synchronicity Counseling.

I (we) understand that access to this information will be limited to determining insurance benefits and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Responsible party: _____ Date: __/___/____

Person(s) receiving services: _____ Date: __/___/____

Person(s) or guardian(s): _____Date: __/___/____

A copy of this form is available for your personal records:

Yes, I would like to receive a copy ☐ No, I do not want a copy at this time ☐