

# THERAPY FEES

**Compassionate Counseling Services, LLC:** Michelle Muff, MA, LMFT

Type of Session:	<b>45-minute session fees:</b>	<b>60-minute session fees:</b>	<b>90-minute session fees:</b>	<b>3 Hour Focus Sessions</b>
Individual, Couple or Family Sessions Face to Face	\$130.00	170.00	\$260.00	\$497.00

*Fees, Rates and policies are adjusted periodically. (5/6/15)*

## **Three Hour Couples Focus Sessions:**

Speed up your progress and make the most of your time with the unique opportunity to spend three hours of intensive counseling working on improving your marriage. During these sessions you will explore areas that need an in-depth analysis. The three hour focus sessions gives you and your spouse the opportunity to express your concerns without the added stress or worry of limited time. The 3 hour focus session is tailored unique to your relationship and focuses on areas that need the most attention. You can choose to use the Prepare/Enrich assessment or the Marital Satisfaction Inventory Revised to target your areas of needed improvement for your marriage. Each assessment provides you will valuable information that targets problem areas and skills set to improve in communication, conflict resolution, finances and sexuality.

## **Health Insurance**

Blue Cross Blue Shield, U-Care, and South Country Health Alliance, Preferred One, and Health Partners are contracted with Compassionate Counseling Services (CCS). These insurance companies will be billed to you by Paragon Billing Inc. Paragon Billing Inc. is a professional medical billing agency and will have access to your personal information. Paragon Billing Inc. manages your Electronic Health Record (EHR) and they will have access to the date, time, type of service provided, and other personal information required to bill your insurance. They will also store the EHR for all clients of CCS. Paragon Billing and their employees are bound by confidentiality rules/HIPAA, and are required to view or use information only as needed to provide their services.

All other health insurance will be billed under Krisma Counseling (KC). K.C. will have access to your personal information. K.C. contracts with a professional Electronic Health Record (EHR) service and a professional medical billing agency. They will have access to the date, time, type of service provided, and other personal information required to bill your insurance. They will also store the EHR for all clients of K.C. These agencies and their employees are bound by

confidentiality rules/HIPAA, and are required to view or use information only as needed to provide their services.

**Record Keeping and request for completion of forms:**

As your therapist I am required by the Minnesota Statutes section 144.292 to provide you a classified and confidential record. These records must minimally contain: 1) client personal data and presenting problem, 2) treatment plan with a diagnosis and justification for it and treatment plan goals, 3) accurate chronological listing of all client contact and a summary of each, 4) records of any consultation or supervision received in relations to the client. 5) a termination statement indicating the date and reason for termination, the client's condition at the time and any recommendations made to the client. 6) copies of all client authorization for release of information and any other legal forms pertaining to the client and 7) a chronological listing of all fees or charges for services related to the client and to whom the fees were charged. If you require additional documentation such as a letter written to a probation officer, forms to be completed for disability or family medical leave, or any other form not listed as part of the MN Statutes 144.292 requirement, charges for the time taken to write or complete this documentation will be billed at the same rate as therapy, unless otherwise agreed upon in advance by this therapist.

**Reimbursement for cash payment with Health Insurance:**

Some insurance companies may reimburse payment for health services to be used towards the deductible cost or in a health savings account. Blue Cross Blue Shield will not reimburse for cash payment. Please contact your insurance company for details and inform them of my credentials prior to submitting your claim.

**Diagnostic Assessment:**

Court ordered diagnostic assessment are done on a cash basis only. If you need a one-time diagnostic assessment for probation requirements the cost is \$350.00 to be paid at the beginning of the session in cash, or credit card. Included in this fee is a 5 page report to be faxed to the probation officer or court official of your choosing with a signed release of information.

**Session Length and Administration of Fees:**

Session length is agreed to prior to the appointment made. Session lengths are agreed to either as a 45 Minute session, a 60 minute session, a 90 minute session or a 3 Hour Focus session. Session length includes the amount of time it takes for payment of services and to book the next appointment time. If you do not feel that you have received the adequate amount of time for your paid service, please address this with your therapist. Session payment is to be made at the beginning of each session.

**Phone Counseling:**

Phone Counseling is offered in conjunction with therapy. You must be a current client to have access to phone Counseling Services.

Each 15 Minute segment will be charged at a \$43.20

For example: A 45 Minute Phone Counseling Session would be charged at \$130.00

A 60 Minute Phone Counseling Session would be charged at \$173.00

**Cancellation Policy**

**If you do not show up for your scheduled therapy appointment, and you have not notified me at least 48 hours in advance, you will be required to pay the full cost of the session. If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.**

**Many clients need and want their appointment time. If you do not notify me 48 hours in advance that you are not coming to your appointment, you are taking away time and service for other clients. Please be understanding of my time and clients' need to be seen and notify me at least 48 hours in advance if you are planning to not attend a session.**

**Please initial here for understanding of my 48 hour billing policy.** \_\_\_\_\_  
**Initial Here    Date**

Compassionate Counseling Services, LLC is dedicated to providing you with high quality mental health care. In order to maintain that commitment we must collect billing in a timely manner. This policy is designed for that purpose.

By agreeing to the above fee schedule, you also give consent to utilizing the payment method you choose (cash, check, or MasterCard/Visa/Discover, (or in the case of insurance being billed through MMFTC) and recognize that payments made through check or MasterCard/Visa/Discover may mean that Compassionate Counseling Services appears on your statements.

As part of the therapeutic process we do not believe it is helpful to participate in a legal process concerning any therapy that we might have given. If you ask that we do so we will decline. If it becomes necessary to participate in a legal process the hourly rate for preparation and testimony in a court hearing is \$100.00/hr and will need to be paid in advance of services.

Payment for cash is due in full at the beginning of each therapy session unless otherwise arranged.

There is a \$35.00 fee for returned checks.

Service(s) may be temporarily interrupted for past due balances or until arrangements for payment are made.

Clients with outstanding balances will not receive requested reports, letters or completion until account is paid in full.

A client may leave therapy at any time, and by signing this document agrees to pay all outstanding fees associated with their account.

Thank you for reviewing our Financial Policy. Please let us know if you have questions or concerns.

I have read the financial policy and hereby authorize Compassionate Counseling Services, LLC to apply the policy on my behalf for services rendered. I request that payment be made directly to Compassionate Counseling Services. I certify the information given is true and correct.

The following fee has been assessed per visit: \_\_\_\_\_

\_\_\_\_\_  
Signature of Client or Responsible Party (Client's Parent/Guardian if under 18)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Michelle Muff, MA, LMFT Date: