SHERMAN COUNSELING
Improving Quality of Life

If you have a change in your ability to pay or have questions regarding our financial policy please call us at (920) 733-2065

FINANCIAL POLICY

We strive to exceed expectation and eliminate financial surprises for all of our patients. We want to partner with you in keeping your account accurate and up-to-date. Your patient financial rights and responsibilities are listed below. Please review and sign this document. The original document will be placed in your patient record and a copy given to you for your records by request.

Sherman Counseling, LLC is a state certified outpatient clinic which utilizes the following fee schedule:

Initial Assessment ----------	$480/hr	**Missed Appointment/Late Cancellation-----**	**$150/hr**
Therapy ----------	$250 - $435/hr	Deposition ----------	$500/hr
Psychiatric Services ----------	$227 - $453/hr	Telephone Consultation (15 min or more)------	$100 - $300/hr
Psychological Testing ----------	$400 /hr	Letters / Report Writing ----------	$250 - $300/hr
Men's Group (private) ----------	$60 / $360		

The financial policy at Sherman Counseling is as follows:

You understand that you are responsible for determining whether services are covered under my health insurance plan.

You will be responsible for the full charged amount if you do not provide Sherman Counseling with my insurance information. You understand you are responsible for any collection fee(s) associated with your account. You further understand Sherman Counseling will honor all discounts, fee schedules, and network participation pricing as per signed contract. Other financial arrangements without a signed agreement with Sherman Counseling will be handled on a case by basis.

All payments are due at the time of service. You understand that if your health insurance does not include coverage for behavioral health benefits, you will be required to pay at the time of service. You understand that you have an option to set up a payment plan with Sherman Counseling for all patient financial responsibility associated with each account. If you are unable to pay your balance in full please contact us to make arrangements for a payment plan.

_____ (Initials) **I am solely responsible for payment for any services provided, including but not limited to: deductibles, co-insurance and/or copayments and denied claims.**
We will assume your deductible has not been met until your insurance company informs us otherwise

_____ (Initials) I understand that I need to cancel an appointment 24 business hours prior to the scheduled appointment or a **NO SHOW / LATE CANCEL CHARGE of $150** will be applied to my account except in the case of emergency. For appointments that exceed an hour in duration, a no show fee will be assessed for each hour scheduled. This charge is not covered by insurance and will be my responsibility.

_____ (Initials) **I have been made aware by Sherman Counseling and understand that services provided are OUT OF NETWORK with my insurance company; which may result in a higher patient responsibility. I am responsible for understanding my out of network benefits.**

Print Name	Client signature	Date
		____/____/_____

Parent - Print Name	Parent Signature	Date
		____/____/_____

www.sherman-counseling.com

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