CYPRESS CREEK THERAPY & RELATIONSHIP CENTER

Karen Berner Arcuri, LMHC
920-920-0189

822 62ND St. Circle E, Ste 101
Bradenton, FL 34208

Financial Policies

Please carefully read the information found below detailing our financial policies. It is important to us that you have a complete understanding of these policies. We reserve the right to amend or make changes to these policies and will notify you in writing. If you have any questions or concerns, please let us know.

List of Fees & Services

Initial evaluation: $125; therapy session (45-50 minutes): $100; therapy session (90 minutes): $150; missed appointment fee: $35; form and letter completion: $75; phone support over ten minutes: $30/15 minutes

Cancellation/Rescheduling & Arrival Time Policy

If you are unable to make your scheduled appointment, please contact the office 24 hours in advance. If you do not show for an appointment or do not give proper notice of cancellation or need for rescheduling, you will be charged a $35 fee. This is a fee to you as insurance companies do not pay for missed appointments. Also, note that if you arrive late for your appointment, you are forfeiting that time. You are required to complete the attached credit/debit card form for Cypress Creek Therapy & Relationship Center,Inc/Karen Berner Arcuri, LMHC to safely keep on file before your first session.

Court Services

Court services are not part of mental health treatment. If you require involvement in any court proceedings, additional fees will apply. Court related fees are not covered by insurance. Court appearances and depositions are billed to the individual requesting the testimony. The fee for these services is $125/hour with a required minimum fee of $250 paid 24 hours in advance. Payment is accepted in Cash, as a Money Order or by Credit Card. There are no refunds. Report writing is billed at $100 per hour and requires 2 hours be paid in advance. A charge of $1 per page will be made for coping of any records.

Insurance and Payment Agreement

I acknowledge that it is my responsibility to know and understand my insurance plan benefits. I will notify Cypress Creek Therapy & Relationship Center, Inc. of any changes in my insurance coverage or participation and provide proper documentation. I understand that all fees for services, co-pays, co-insurance amounts and deductibles are due at the time of the service. I understand that there is a $35 fee for a returned check. I understand checks may no longer be accepted if a check is returned for insufficient funds-payment will need to be cash or by credit/debit. I understand an account is considered delinquent if there has not been a payment made within 30 days following written notification of the balance due. I understand that the unpaid balance will then be subject to a monthly finance charge of 15%. Any portion of the account balance over 30 days past due will be submitted to a collection agency and continue to accrue interest. I also agree to pay all collection costs on any unpaid balance on my account, generally 50% of balance. I acknowledge responsibility for any payments due to Cypress Creek Therapy & Relationship Center, Inc. or Karen Berner Arcuri, LMHC for services provided or fees as previously outlined above.

I have read and agree to the above financial policies.

Name (Print) Signature Date

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Credit Card Authorization Consent Form

Clients are required to keep a valid credit card number on file. This credit card will only be used for missed appointments, late cancellations (not made at least 24 hours in advance of appointment time), or delinquent balances (balances more than 60 days past due). This card will not be used for any other reasons than the above stated terms.

Patient Name (print):_____

Cardholder's name: _____

Card Type (circle one): Visa MasterCard American Express Discover

Card Number: _____

Expiration Date: _____/_____ (mm/yy)

3 Digit CVC/Security Code_____

Credit Card Billing Zip Code:_____

I have read and understand terms of this credit card authorization form. I authorize Cypress Creek Therapy & Relationship Center, Inc/ Karen Berner Arcuri, LMHC to keep my credit card number and my signature on file and to charge my credit card listed above for missed appointments and/or late cancellations at the rate of $35, and for any delinquent balances more than 60 days past due.

Cardholder's Signature: _____Date_____

Therapist Signature:_____ Date _____