FEE POLICY AND CONTRACT FOR PAYMENT

To proceed with our professional relationship I ask that you agree to the following policies and procedures:

1. Payment for service is expected on the date services are provided (unless other arrangements have been made). You can elect to bill your insurance company for direct reimbursement, or, you can assign payment to me and I will bill your insurance company as a courtesy to you. If I am a preferred provider or under a managed care contract, we will follow the procedures of that specific contract.

2. Appointments must be canceled within 24 hours to avoid being charged.

3. Phone calls of more than five minutes will be charged on a proportional basis of the hourly fee.

4. Additional services outside of the normal therapy time will be charged on a proportional basis of the hourly fee, ie; reports, consultations requested by you. If ever required, rates will be discussed for any testimony I may be asked to provide regarding your treatment/evaluation, either in court situations or depositions.

5. If you do not utilize the professional services of Robert Stuyvesant, LCSW, MFT for any period over sixty days (unless treatment sessions have been scheduled for intervals of that length or longer), the therapist-client relationship shall be considered terminated. Financial obligations and confidentiality remain intact. You may always choose to resume treatment with me, however, if treatment has been terminated either through agreement or default for failure to utilize my services, immediate appointments may not be available.

CONTRACT FOR PAYMENT

Unless otherwise specified, the fee for each forty-five to fifty-minute session (individual, couple or family) is one hundred -fifty dollars ($150). This fee is also applied to the time involved for additional services, ie; **reports, phone consultation, etc. If you require my services for depositions, court purposes, or testimony, special assessments/evaluations, my hourly fee is $350 per hour, including preparation time.**

TERMS

1. I agree to pay for all services and expenses.

2. I agree to pay the fee at the time of service, regardless of insurance, unless other arrangements have been made. I understand Robert Stuyvesant may bill insurance for me, but only as a courtesy and I am responsible for each session.

3. I have contacted my insurance company in the event I am using insurance, to verify coverage for outpatient mental health services provided by a licensed clinical social worker and/or a licensed marriage and family therapist. My annual deductible is $_____and the amount unmet on my deductible is $_____.

4. I agree to pay for sessions that I do not keep or cancel without 24 hours notice, before re-scheduling my next appointment. I recognize I am responsible for payment for services provided. Insurance coverage may or may not reimburse for these services and I am ultimately responsible to pay for the services received.
I, _____, assume financial responsibility

for the services provided to _____, by Robert

Stuyvesant, LCSW, MFT. I agree to abide by the terms listed above.

Signatures:_____ **Date:**
_____ **Date:**

_____ **Date:**