

Inner Directions Counseling

Meaning~Options~Empowerment

_____ I understand that a ***24 hours notice of cancellation is required***. I also understand that if I cancel an appointment with less than 24 hours notice or if I fail to show up for a scheduled appointment, Cherylann will ***bill me for the full cost of the therapy session missed***, which must be paid before the next session. Most insurance policies do not pay or reimburse for missed appointments.

_____ I understand that the fees for therapy are as follows: The cost of each 45 to 60 minute session (90834 is 45-50; 90837 is 53-60 minutes) is \$125 and for each 61 to 80 minute session is \$180. For diagnostic assessment 90791, the charge is \$180.

_____ I understand that ***payment (co-pay and/or deductible) is due at time of service***. In cases where Cherylann is an Out-of-Network provider, I understand that it is ***my responsibility to pay for my therapy in full*** and secure reimbursement from my insurance company.
____EAP Client / ____Ins Client / ____Private Pay with Ins/____Private Pay only

_____ I understand that any fees charged by the bank for non-payment or returned checks will be billed to and reimbursed to Cherylann by me, and I will pay those fees along with the value of the returned check before or at the next session.

_____ I understand that in order to use my insurance, mental health services must be medically necessary; a ***DSM-IV/DSV-V diagnosis is required in order to bill insurance***; and the insurance company has a right to review my client records. I give permission for Cherylann to speak directly with my insurance carrier regarding questions related to coverage and/or billing and/or inquiries related to care.

_____ I give permission to Cherylann to ***present my case in consultation*** with other professionals or consultants, who are bound by the legal framework of privacy and confidentiality, for professional development and guidance purposes.

_____ I understand that Cherylann ***does not take evening and weekend crisis calls***, and that if I should need emergency crisis management on evenings and weekends, I will call 911 or the Journey Crisis Line or the National Crisis Line.

I have reviewed and understand this information as well as that contained in the Informed Consent; I have received HIPAA notification.

Name

Date

Cherylann Ganci, LMFT

Date