



1538 E. Warner Ave.
 Suite E
 Santa Ana, CA 92705
 Phone: 714-751-7790
 Fax: 714-751-7791
 chlcsw@pacbell.net

FEE AGREEMENT

Effective 1/1/2011

I(We), _____ agree to pay for the
 treatment of _____ by The Institute for Child and
 Family
 Development.

I(We) agree to be responsible for payment to The Institute for Child and Family
 Development for all services rendered. I(We) understand that the staff of The Institute
 for Child and Family Development will assist us in collecting insurance reimbursement,
 but that I am (we are) ultimately responsible for obtaining this reimbursement. Costs of
 sessions are as follows:

PSYCHOTHERAPY FEES

Individual or Family Psychotherapy, 100 minutes	\$300.00
Individual or Family Psychotherapy, 75 minutes	\$225.00
Individual or Family Psychotherapy, 50 minutes	\$150.00
Individual or Family Psychotherapy, 25 minutes	\$ 70.00
Individual or Family Psychotherapy, 15 minutes	\$ 35.00
Three-session assessment	\$675.00
Three-session assessment with report	\$975.00

INTENSIVE PSYCHOTHERAPY FEES

One-week intensive program (children)	\$4,950.00*
Additional sibling intensive done concurrently	\$2,475.00*
Two-week intensive program (children)	\$9,900.00*
Additional sibling intensive done concurrently	\$4,950.00*
One-week intensive program (adults)	\$3,000.00*
Two-week intensive program (adults)	\$6,000.00*

*If the level of complexity for any particular case requires the use of additional treatment professionals other than those included in the intensive program, this rate may increase. In this event, clients will be so advised and additional fees discussed in advance.

Additional intensive program charges, if needed:

Follow-up treatment	\$150.00/hr. per therapist
Psychological testing	dependent upon tests needed
Follow-up consultation with hometown therapist	no charge

NOTE: There is a 50% non-refundable deposit required for intensive programs, due one month prior to the start of the intensive. The balance is due the first day of treatment. Payment is accepted by cashier’s check only (no personal checks).

Clients are expected to pay for services at the time they are rendered unless other arrangements have been made. Please notify your therapist if any problem arises during the course of your therapy regarding your ability to make timely payments. Clients who carry insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. You will be provided with a receipt that you can submit to your insurance company for reimbursement. If the insurance company has forms for the psychotherapist to complete, be certain to give them to the therapist at your earliest convenience. In instances where extraordinary professional time is required, you may incur additional fees.

The above costs include administrative fees. We do not charge for phone conversations unless they exceed ten minutes or they become excessive in frequency. If you become involved in any litigation and we have to appear in Court, write a report, or give testimony, we will charge \$260 per hour, payable in advance. The same charges apply to travel time.

Extra services such as contacts with others (e.g. psychiatrists, social workers, previous psychotherapists, school personnel), correspondence or report writing will be billed at \$150 per hour.

Travel time (such as travel to and from home visits, school conferences, meetings with others involved in client's treatment) will be at \$150 per hour or fraction thereof. Report writing will be billed at \$150.00 per hour or fraction thereof.

We do understand that emergencies can arise which may prevent you from keeping your weekly appointment. We will therefore balance off your needs and ours in the following fashion: If you give us 24 hours notice of your intention not to use your appointment time, we will not charge you for the time. With such notice, we can make alternative plans. If you fail to provide us notice at least 24 hours in advance, or if you fail to show up as expected, we shall charge you for the time at the usual rate. Please note that insurance carriers do not reimburse for missed appointments and often require that such missed appointments be so noted on your statement of charges. Repeated failures to attend scheduled sessions or to provide adequate rescheduling notice may lead to termination of our work together.

I (We) understand that Intensive Programs require at least two weeks notice for cancellation.

I(We) have carefully read and fully understand this Fee Agreement and will abide by its terms.

_____ Date: _____
Client (if minor, parent or guardian)

_____ Date: _____
Parent or guardian

_____ Date: _____
Parent or guardian

We accept reimbursement from the Victims of Crime Program.

Dear Client:

Thank you for scheduling your appointment with us. Because we have blocked off time to address your needs, we do charge a no show and/or cancellation fee of \$150.00. We require a minimum of 24 business hours notice of cancellation. In order to cancel your appointment and put another client in your time slot, we require a phone call to a staff member, or an E-mail, at least 24 business hours prior to your appointment.

Please provide your credit card information below, authorizing us to charge the card for any outstanding balance owed on your account, including \$150 for appointments canceled with less than 24 business hours notice.

We look forward to helping you with your needs. If you have any questions, please contact us at 714-751-7790.

I authorize The Institute for Child and Family Development or Connie Hornyak, LCSW, to charge \$150 to my credit card if I do not show up for or cancel my appointment without a 24 business hours notice. If my balance is more than 30 days past due, I also authorize charging my credit card for the full amount due.

Name: Print _____

Sign _____

Please circle one: Visa, MasterCard

Expiration Date: _____ 3 Digit Code on Back _____

Billing address: _____

Billing Zip Code: _____