**Elizabeth Fariello, LCSW, LLC (License #0904009218)**

**203A Church St. SE, Office A**

**Blacksburg, VA 24060**

**540-695-0250/lotuscounselingandcoaching@gmail.com**

**Financial Agreement**

**FEE SCHEDULE**

Initial Evaluation $125

Therapy Session/Hypnosis Session (45 to 60 minutes) $100

Late Therapy Cancellation (less than 24 hours) $50

Missed Therapy Appointment (no-show) $50

Court Appearance Retainer $500

Court Appearance Fee/Depositions per hour $300

Phone Consultation/Professional Fees per hour $90/$300 (court related)

Short letters or documentation $25

**INSURANCE PROCESSING**

In accordance with the services that will be provided by Elizabeth Fariello, LCSW I hereby agree and authorize my insurance company to pay this agency in full for services rendered in accordance with my medical benefits as agreed to in my insurance policy. I hereby authorize Elizabeth Fariello, LCSW to release to my insurance company any information necessary for seeking reimbursement services.

**My insurance company is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .**

**The amount of my co-payment is $\_\_\_\_\_\_\_\_\_\_\_\_ as assigned by my insurance company.**

Your insurance company may require that you pre-authorize your treatment with me prior to your visit. It is your responsibility to monitor insurance benefits, deductibles, as well as effective and termination dates of coverage. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have any questions, please contact your plan administrator. Feel free to speak with me if assistance is needed with this. By signing below, the undersigned affirms that he/she has read, understands and agrees to the finance agreement as outlined above. I authorize my insurance company to make payments directly to Elizabeth Fariello, LCSW LLC for services rendered.

**I hereby authorize Elizabeth Fariello, LCSW, to release to my insurance company any information necessary for seeking reimbursement for the services listed above.**

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE DECLINE/SELF PAY**

If you do not wish to use your insurance to cover and/or reimburse you for the cost of psychotherapy services, please read, sign and date below:

**I hereby do not authorize Elizabeth Fariello, LCSW, to release to my insurance company any information necessary for seeking reimbursement for the services listed above.**

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_