EDEN COUNSELING, LLC
(248) 602-0322

NAME:
DATE OF BIRTH: _____

PATIENT FEES AND PAYMENT AGREEMENT

This provider will bill usual and customary fees for standard services offered.

Additional services not covered by insurance companies:

Letter writing, consultation, form completion	$90.00	(every 20 minutes)
Late cancel or no-show fee	$90.00	

(Your therapist reserves the right to re-evaluate this fee if there is a pattern of missed or late canceled appointments.)

Returned check fee	$35.00

I understand payment for services is due at the time services are rendered. Statements will not be sent for current patients, unless arrangements have been made. I understand any deductibles and co-pays are my responsibility and due at the time of service. I understand any deductible or co-pay applicable to my policy is best explained by my insurance carrier.
I understand there will be a charge of $35.00 for any returned checks. I also understand that Eden Counseling, LLC reserves the right to use an outside collection agency as a means of collecting an outstanding balance if my account remains unpaid or payment arrangements are not made. I understand that if my account goes to collections, I will be assessed an additional $25 or 35% collections fee, whichever is more.

I understand it is my responsibility to keep scheduled appointments or notify Eden Counseling, LLC 24 hours prior to scheduled appointment or be charged a $90.00 no show fee. This fee is due at the next appointment and cannot be billed to your insurance carrier. In the case of emergencies, this provider may grant an exception.

Fees are subject to change without notice.

PRIVATE PAY

For patients not utilizing insurance, usual and customary fees of Eden Counseling, LLC apply unless a different rate is listed below.

Service Provided _____ $_____

I HAVE READ, UNDERSTAND, AND AGREE WITH THE FINANCIAL CONDITIONS DESCRIBED ABOVE.

_____	_____	_____	_____
Patient/Parent/Guardian Signature	Date	Witness	Date