LAURIE KIMMEL, LMSW, ACSW
FEE AGREEMENT and INSURANCE INFORMATION

Patient's name_____ Date: _____

IT IS IMPORTANT THAT YOU VERIFY YOUR INSURANCE COVERAGE. YOU ARE RESPONSIBLE FOR PAYMENT FOR SERVICES NOT PAID DIRECTLY TO LAURIE KIMMEL, LMSW, BY YOUR INSURANCE COMPANY.

1.**Charges for services**: The fee for session for your therapy is dependent on your contract. Fees may change from time to time. To the extent possible, you will be notified well in advance if this were to occur. If you have insurance coverage, read the items listed under number two. If you do not, you are personally responsible for the payment for all services rendered with Laurie Kimmel. LMSW. Unless other arrangements have been made, payment is expected the time services are rendered.

2.if you have insurance: Insurance only covers the cost of sessions you attend. Please note my policy regarding changes for missed sessions parentheses (see #3 below).

a. If you have a deductible under your insurance policy, all charges for your therapy are your responsibility until this deductible is met.

b**. When fees for your therapy are paid fully or in part by an insurance company, you might have an annual maximum beyond which your insurance will not pay. Once your maximum is met, the full cost of therapy becomes your responsibility. If your insurance company pays for a proportion of your therapy, the remaining portion (your co-pay) is your responsibility.**

c. Your insurance company may utilize the managed-care company which must authorize any services provided as a precondition to insurance covering the services. Discuss this with Laurie Kimmel, LMSW whether this will apply to your therapy.

d. Under some insurance, there is no provision for the direct payment of fees to Laurie Kimmel, LMSW. In this case you are responsible for paying the full fee. However, upon submission of copies of your paid invoices to your insurer, many companies will reimburse you for a portion of what you pay. Contact your insurance company to obtain specific permission about reimbursement; this information will not be provided to anyone other than yourself or a family member

e. Your insurance company will be billed starting with the month in which you give me your insurance card information. I cannot bill retroactively for appointments. Dates prior to notification of insurance will be your responsibility.

3**. Missed sessions: If a scheduled appointment needs to be cancelled, please notify me more than 24 hours in advance. A charge equal to what your insurance would have paid for our regular appointment will be charged to you.**

4**. <u>All copayments are due at the time of each session.</u>**

By typing my signature on the line below, I am agreeing that I have read, understand and agree to the items contained in this document.

Patient: _____ _____

Date: _____ Laurie Kimmel, LMSW