**Brianna White, LMFT**
**Intrepid Counseling LLC**
**565 Wimbish Road**
**Macon, GA 31210**
**833-825-9991**


**Intrepidcounseling.org**
**brianna@intrepidcounseling.org**
**GA License #: MFT001769 ; WA License #: LF60567087**

# Financial Agreement

**Therapist Name: Brianna White, M.S., LMFT**

**Client Name:_____**

## Fees

Our first meeting will be a free consultation, up to 30 minutes. If we agree to continue together, our next meeting will be a Mental Health Assessment which costs $200. This meeting typically takes 60 -90 minutes and includes a formal write-up which can be shared with your physician. After this, my session fee is $110 for each 45 - 55 minute session. Usually we will have one session per week, though some people need more or less frequent sessions. If this fee is not possible for you, please ask to discuss options with me.

Letters you may request from me will cost $50 each and require two weeks' notice.

Between-session phone calls longer than ten minutes or will be charged at a rate of 10$ for each 10 minutes after the first ten.

You will be charged the full session fee for sessions you do not attend unless you cancel more than 24 hours in advance. If we can reschedule within the same week, I waive the cancellation fee for the missed appointment.

## How To Pay

You may use PayPal or credit card to submit payment after each session. This will be facilitated through the Adaptive Telehealth Software. PayPal may send you emails as a part of this process. Alternatively, you can write a paper check.

# Failure to Pay

Falling behind on session fee payments may ultimately result in our needing to end our treatment relationship. It will be your responsibility to communicate with me openly if you begin to struggle with the fees so that we can problem-solve together.

# Using Insurance

Upon your request, I can provide you with a receipt called a Superbill that you can submit to your insurance company for reimbursement. I am currently Out of Network for all insurance companies. Sometimes my services might be treated as in-network if there is not in-network provider near you.

To understand how your insurance handles your mental health coverage, call or email your insurance company's customer services department and ask the following questions:

- What are my mental health benefits?
- What is the coverage amount per therapy session?
- How many therapy sessions does my plan cover?
- How much does my insurance pay for an out-of-network provider?
- Is approval required from my primary care physician?

The client is the responsible party unless they are a minor and a parent has consented for their counseling. In that case the parent/guardian is financially responsible. If a third party should be billed for your counseling, please complete the third party payer consent form at the end of this document.

Your signature below indicates that you understand and accept this fee structure and will be responsible for the payment for these counseling services.

Unless a parent/or guardian has consented for the counseling, the client signs below.

**Signature of client: _____**

Continue below if a parent/guardian is consenting for a minor child.

**Name of parent or guardian:**

_____

**Consenting parent/guardian signature:**

_____

# Third party payer consent:

If a third party is to be billed for these services, please specify their name and contact information below. If this third party does not pay, you will be responsible to pay for this counselor's services.

**Third party payer name: _____**

**Third party payer email: _____**

**Third party payer phone number: _____**

**Relationship to client/parent/guardian (ex: parent): _____**

**Signature of client or parent or guardian:_____**

**Request to Release Billing Information:**

I request Brianna Nystrom White, LMFT to disclose my private health information as needed to coordinate billing with the person I have identified below.

Name of person to receive billing information: _____

Relationship to me: _____

This authorization of disclosure of my health information will expire 90 days after the termination of clinical services unless an alternative expiration date or event is specified here:
_____

I understand that my protected health information disclosed pursuant to this agreement may be subject to redisclosure by the recipient and in such cases may no longer be protected by state or federal rules of confidentiality.

I understand that I have the right to refuse to sign this form for authorization to disclose or release my protected health information and that my refusal to sign this authorization will not adversely affect my ability to receive health care services.

I understand that I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed as described in this authorization unless action has already been taken in reliance on this authorization.

_____ _____
Client Signature Date

_____
Print Client Name