Everlasting Solutions Counseling Services, Inc.
601 Main Street, Suite 300, Vancouver WA 98660 360-993-0577

Fees and Contract

1. I agree to enter into therapy with Julia Berreth, M.A, L.M.F.T. and Everlasting Solutions Counseling Services, Inc. otherwise known as ESCS.

2. **I agree to pay fees designated in the fee schedule or any co-pays and/or co-insurance payments. Any reports prepared per client request will be charged the hourly fees indicated in the fee schedule. Client will be notified 30 days in advance in writing of any increase in fees. Payment is due at time of service. Any advance payments made and not utilized and/or client wishes to terminate services prior to funds utilization for services will be refunded within 30 days. Funds will be deducted for any late cancellations or no shows.**

3. I understand if I am late for a session, the session may be shortened and I will be required to pay for a full session. I further agree that if I am late and haven't called, the undersigned therapist will wait up to 15 minutes and will assume I am not coming**. If I do not notify the therapist 24 hours prior to the appointment and/or I do not appear for the scheduled time I understand the FULL FEE will be charged for the time reserved.**

4. I understand that for any payment not received as a result of a returned check for **non sufficient funds or any other reason, I will be billed the amount of the session plus an additional $25.00 for processing and bank fees.**

5. I understand that my therapist may engage a collection agency and/or other legal measures to recover any unpaid balance, but will give me reasonable notice before taking any such action. I also understand that if any such actions are taken, the therapist will not reveal any clinical information during these procedures.

6. I understand that I or my therapist can submit forms to my insurance company and I or my therapist may be eligible to receive reimbursements from them. **I understand that my therapist has no obligation to collect payment from my insurer. I understand that it is my sole responsibility to pay for services and any late cancellation and/or no show fees in full without regard to my insurance coverage**. I agree that if I request insurance claims to be made to my insurer that this may require a clinical diagnosis. I understand that my therapist will discuss what this diagnosis is, and what it means, so I can make an informed decision before submitting it to the insurance company.

7. I understand that I can leave therapy at any time and that I have no moral, legal, or financial obligations other than those already accrued.

By signing below I am indicating that I have read and understand ESCS Disclosure Statement, understand my rights as a client, accept financial responsibility for payment as indicated above, and have received a copy of the fee schedule and ESCS Privacy Notice (HIPPA).

Name:_____ Date:_____

Name:_____ Date:_____

Therapist:_____ Date:_____