Riesmeyer Counseling Services, LLC
Kathryn L. Riesmeyer, MA, LPC, NCC
955 Executive Parkway, Suite 221, Creve Coeur, Missouri 63141 314-303-2937

Fee Agreement

As a small business owner, I thank you for your cooperation and understanding of the need to keep up to date on any balances due/fees to be paid, changes in your insurance policy or other pertinent information related to fees for service. The preferred method of payment is cash or check; debit/credit/health savings cards are accepted. Please note: if you use your insurance, coverage, benefits, deductible/co-pay information is not guaranteed until the claim is submitted/processed and an explanation of benefits is received. Please ask Kathy if you have questions about the potential financial obligation for your sessions.

Please complete either Section A or Section B, according to your preference.

SECTION A.
I am using my insurance benefits provided through_____

Assignment of Benefits
By my signature below, I authorize the release of any medical or other information necessary to process my behavioral health insurance claims. I also request payment of government benefits (if applicable) either to myself or to the undersigned provider who accepts assignment.

Client Initials_____

Authorization of Payment
By my signature below, I authorize payment of medical benefits to the undersigned provider of services.

Client Initials_____

SECTION B.
I am paying Riesmeyer Counseling Services, LLC directly for services rendered. The fee is $150.00 for a 55-60 minute session or $125.00 for a 45 minute session, paid by cash, check, debit, credit or health savings account card.

Client Initials_____

FINANCIAL INFORMATION
Please provide your Credit Card/HSA/Debit Card information, authorized for the payment of any fees not collected at the time of service including: copays, deductibles, balances on account, and missed/late cancellation appointment fees. The information collected will be stored with your HIPAA compliant medical chart.

Card Type_____ Number_____

Expiration Date_____ Security Code_____ Zip Code for Card_____

Exact Name on Card_____

My signature below authorizes Riesmeyer Counseling Services/Kathryn Riesmeyer to collect **overdue** co-pays, deductibles, balances on account and missed/late cancellation appointment fees as stated in the Consent to Treat.

Signature of Cardholder_____ Date_____

<u>Balances Due/Statement of Agreement</u>
Balances due can be a result of an insurance deductible, change in co-pay or co-insurance, denial of coverage or other reason. I agree and accept responsibility for balances due on my account.

_____ _____
Client Signature Date

_____ _____
Kathryn L. Riesmeyer, M.A., L.P.C., N.C.C. Date
for Riesmeyer Counseling Services, LLC