Julie Johnson, MA, LCPC **2656 W. Montrose Ave Suite 105 Chicago, IL 60618**
Licensed Clinical Professional Counselor **773-383-7033 www.juliejohnsonlcpc.com**

FINANCIAL AGREEMENT

I/We_____hereby agree to pay a fee of $_____(co-pay, coinsurance, deductible and/or self pay) per session to Julie Johnson, MA, LCPC for therapy services rendered to me.

Fees:

My fee is currently $125.00 per 45-50 minute therapy session. In some situations, a reduced rate/fee is available. If you are utilizing insurance benefits and I am an in network provider, these fees will be reduced by allowed contracted amount and benefit plan with insurance company.

Payment:

You are expected to pay for services at each session. If you are utilizing insurance benefits, you are expected to pay your deductible, co-pay or coinsurance amount as estimated by your insurance quote of benefits. If actual payment by your insurer differs from what was expected, a financial adjustment will be made promptly. Currently, the acceptable forms of payment are cash, check or credit card, payable to Julie Johnson, MA, LCPC. If your check is returned for any reason, you will be expected to pay any bank or overdraft fees.

1. **If you choose not to use insurance for psychotherapy services or if you are covered under a plan for which I am not an in-network provider, or if you are not insured, you will be expected to pay the full fee for each session. In some situations, a reduced rate/fee is available.**

Please be aware that you and not your insurance company are responsible for full payment of the fee that we have agreed to. If for any reason your plan does not cover the services provided or covers them at a different level than was originally understood, you are responsible for full payment of fees.

Cancellation policy:

I maintain a standard 24 hour cancellation policy. If you need to cancel an appointment, please notify me at least twenty four (24) hours in advance of your appointment time. If you DO NOT provide 24 hours notice of a cancellation, or you miss or fail to show up for your appointment, you will be charged the full amount for the session.

My/Our signature below indicates that I/We have read and understand the information provided in this financial policy and agree to abide by its terms.

_____ _____

Client Signature **Date**

_____ _____

Client Signature **Date**