



POSITIVE FRAME OF MIND  
COUNSELING PLLC

## PFOMC Fee Policy--Kenda F.

The office will verify your coverage for services including deductible and co-payment, and out of network benefits if we're not a provider with your insurance company or third party carrier your benefits. We will file your insurance claims unless informed otherwise. *We request that you verify these provisions with your insurance company.* Your insurance policy is a contract between you and your insurance company. *Therefore as the insured, you are solely responsible for payment(s) refused or determined unnecessary by your insurance company.* Sometimes insurance companies may misinform our office about patient benefits, and we do our very best to acquire correct information as soon as possible. All insurance benefits will be assigned to Kenda Finn, M. Ed., LPC. This assignment will remain until revoked by the client. Although it is possible that your mental health coverage deductible may have been met elsewhere, the amount will be collected until the deductible payment is verified by the insurance company.

*Clients are responsible for payment at the time of services. Court Testimony Fees are to be paid in advance with refunds provided if necessary. We accept cash, personal checks, Mastercard, Visa, American Express, and Discover. If we have not received verification of benefits from your insurance company at the time of your first session, the full fee will be charged. If you have overpaid, you will be reimbursed.*

### Office Fees

Insurance Code	Description	Time	Fee
90791	Intake	60 min	\$145
90834	Individual Therapy	45-50 min	\$125
90837	Individual Therapy	51-60 min	\$125
90847	Couple/Family Therapy	45-50 min	\$125
90853	Group Therapy	60 min	\$125
Not Billable to Insurance	Late Cancellation/No Show	N/A	\$55
Not Billable to Insurance \$40	Returned Check (NSF)		N/A
Not Billable to Insurance	Fees, Letters & Reports	15 min +	\$35
Not Billable to Insurance	Letters for Court & Disability letters	15 Min +	\$100
Not Billable to Insurance	Court Testimony, Preparation	30 min	\$ 100 paid in advance

**\*\*\*\*If counselor is required to testify in court, daily court fees will be discussed and applied.**

I understand that I am financially responsible to Kenda Finn, M. Ed., LPC for the charges incurred by me and/or my dependents. My signature below acknowledges my sole responsibility in paying for any fees not covered by my insurance company at the time of service.

Client's Signature or if client is a minor --Parent signature

Client Printed Name-- If client is a minor-- Parent Name & Date

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Date

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