East Cascade Counseling Services LLC

731 NW Franklin Ave. Suite 107
Bend, OR 97703
541-306-1128 Phone
541-647-1162 Fax

Client Policy Statement

Appointments

Therapy sessions are scheduled by appointment. Your appointment times are reserved exclusively for you and cannot be changed on short notice. Missed appointments get in the way of progress in therapy. Missed appointments or those not canceled (or rescheduled) at least 24 hours in advance will be billed a cancellation (or no show) fee of $75 for the first appointment, any subsequent will be billed at full fee, $185. It is important for you to know that insurance companies do not pay for missed appointments; therefore you are responsible for payment of the full fee. Missed appointments need to be paid in full prior to rescheduling. We are a small group practice and missed appointments impact our business and therapeutic progress, therefor; we reserve the right to terminate services after three missed/late cancel appointments.

Payment and Billing

We do bill most health insurance companies. It is your responsibility to review your health insurance policy for coverage and benefits (co-payment amounts and deductible information). Please be aware of this information prior to your first appointment. It is important that you understand that you are still ultimately responsible for payment of all services received.

If you will be paying for services out of pocket, payment in full is due at the start of each session, so please have payments ready. If you are paying by check, please have check ready payable to East Cascade Counseling Services LLC. We accept credit card payments for sessions or copays on our website, eastcascadecounseling.com. Please make payment prior to session. A receipt for payments will be sent upon request.

Termination

Multiple missed appointments or delinquent payments are grounds for the therapist to terminate future therapy sessions. All fees are due in full at termination or final therapy session. It is important that you understand delinquent accounts, will be sent to collections.

Other payment or fee arrangements must be made in advance and agreed upon (see page 2). If you have any questions feel free to discuss them during our next appointment.

Please initial the following:

_____ I have received and read a copy of ECCS Professional Disclosure Statement.

_____ I certify that I have read and understood the above statement, have had all questions answered, that I have received a copy, and that I agree to it's terms.

Client Signature: _____ Date: _____

If Client is a minor, Responsible Party Signature:_____ Date: _____

Therapist Signature: _____ Date: _____

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Payment Arrangement

Payment arrangements:_____
_____
_____

For your convenience, we are happy to keep a credit card on file for payment of services, copays or balances. Please note all credit card information is kept secure and private. Any unpaid balances will be charged at the final therapy session or at termination. A receipt for payments will be sent upon request.

Please select card type: Visa MasterCard AMEX HSA

Credit Card number: _____

Name as it appears on the card: _____

Expiration date: _____

Security code: _____ (3-digit code on the back, AMEX 4-digit code on front)

Billing zip code: _____ (where statements are sent for this card)

I agree to East Cascade Counseling Services LLC keeping my card on file and charging for sessions, copayments and missed appointments.

Signature: _____ Date: _____

Therapist Signature: _____ Date: _____