8008 SLIDE RD. #31 LUBBOCK, TEXAS 79424
(806) 300-0898 OFFICE (806) 701-5422 FAX

Session Fee Agreement

Payment is expected in full at the time of services.

Please check one:

☐ Private Pay
Self Pay Rate: $80.00/session

☐ EAP (Employee Assistance Plan)
Company Name: ___________________________
Auth #/Cert #: ___________________________
# of visits authorized: ___________________________
Dates authorized: ___________________________

☐ Insurance
My Copay is: ___________________________
Insurance carrier: ____
Insurance ID number: ____
Name on card: ____
Physical address of insured: ____
____
Date of Birth of Client: ____

All clients using health insurance please sign below; parent must sign if client is under 18
I, the undersigned, have insurance coverage with the stated insurance company and assign directly to Rise Counseling, all medical benefit payments for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I agree that a photocopy of this authorization shall be as valid as the original.

____ ________________________
Signature (Client, or parent or guardian if client is under 18 years old) Date

- -

Your counselor will fill this section out during your first appointment

Fees for Services:

One hour (50-55 min) .... $__________

45 min... $__________

Missed Appointment fee..................... $ 50.00

Late Cancellation fee............................ $ 50.00

Client Signature: ____ Date: ______________

Counselor Signature: _____________________________________ Date: _____________