RONDA KIMBALL, MS, LPC ASSOCIATE, EMDR TRAINED,

CMHIMP, CTP, CYI

Supervised by Dr. Russ Bartee LPC-S

817-771-2728 innerlife122@gmail.com rondakimballlpc.com

## Fee Information and Office Policy

***Financial policy***

Thank you for trusting me as your health care provider. I appreciate your trust and I appreciate the opportunity to serve you. I am committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of my Financial Policy, which I require you to read and sign prior to any treatment.

Because I am a Licensed Associate supervised by Dr. Russ Bartee, LPC-S as prescribed by the state of Texas, all payments will be received by Logos Counseling.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE**

* **I accept cash, Credit Cards (Visa, Mastercard, Discover Card, American Express, and some health savings cards), Money Orders and Checks.**

***Regarding Insurance:***

If you wish to be reimbursed by your insurance company please let me know so I may provide you a receipt for you to submit your claim.

**My rate is $90.00 for initial assessment and then $90.00 hourly**

Adult patients are responsible for full payment at the time of service. The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment at the time of service and will also be required to sign a Consent to Treatment Form.

***Missed Appointments:***

Unless an appointment is cancelled at least 24 hours in advance, my policy is to charge $90.00 for a missed session. If an absence is unavoidable (illness, crisis, etc.) this will be considered prior to charging the missed appointment fee. Please help me to serve my patients better by keeping scheduled appointments. By signing below, you are indicating that you read and understood this policy, that any quest ions you had about this policy were answered to your satisfaction, and that you were furnished a copy of this Financial Policy.

Printed Name of Patient or Responsible Party

Signature of the Patient or Responsible Party Date

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Signature of the Therapist Date

RONDA KIMBALL, MS, LPC INTERN, CMHIMP

Supervised by Tamara Allen Bush, LPC-S

817-771-2728 innerlife122@gmail.com rondakimballlpc.com Tamara Allen LLC

**Fee Information and Office Policy**

**Credit Card Authorization Form**

Name on card:

Address: City, State, Zip:

Home Phone: Cell Phone: \_

VISA □ □ MASTERCARD □ **AMERICAN** EXPRESS □ DISCOVER

Account Number: \_ Security Code: \_

Billing Zip:

Exp. Date: \_

Charge Card may be used for : □Session Fee □ Unpaid Balance □ Cancellation

□ Receipt Emailed □ Receipt Mailed via USPS

By signing this form, I authorize Tamara Allen, LLC and their billing workplace representative to charge my card for services provided by Ronda Kimball, LPC Intern under the supervision of Tamara Allen Bush LPC-S above until cancelled in writing. I understand the amount may change if different services or materials are provided.

Print Cardholder Name

Signature of Cardholder /Client Date: