kTherapy / Brainspotting with Katherine
45 Lyme Road, Suite 310A • Hanover, NH 03755 • 833-4-BSPKAT (833-427-7528)

FINANCIAL PRACTICES

ALL FEES ARE PAYABLE AT THE TIME OF SERVICE

Fees for Services: Therapy sessions are fifty-five- (55) minutes in duration at a charge of $200.00. Brainspotting sessions are $250 for ninety (90) minutes and $100 for each additional thirty (30) minutes. If insurance benefits are utilized, you are responsible for all co-pays or deductibles at the time services are rendered.

Adjusted Fees and Payment Schedules: Adjusted fees and payment schedules must be worked out with your clinician prior to scheduled treatment; they will be based on need, and held confidential.

Payments for Services: Fees/co-payments are to be paid at the time of the session, unless otherwise arranged with your clinician. Please make checks out to "kTherapy" or to the name of your clinician. There will be a $20.00 charge for all returned checks. Any outstanding balances of over 30 days are subject to a 10% interest charge.

Regardless of medical coverage, you are responsible for your fees for professional services. Clients who default on their financial obligations will be referred to a contracted collection agency and revoke the right to confidentiality in this process. Defaulting clients will be liable for all collection costs including agency fees and legal fees.

Cancelled or Missed Appointments: If you are unable to attend your scheduled appointment, a minimum of twelve (12) hours notice must be given in order to avoid a missed appointment fee.

If less than 12 hours are given before cancellation or an appointment is missed without cancellation (no-show), you will be charged a $100.00 missed appointment fee plus a $5.00 processing fee. Insurance will not cover any of this cost and you are responsible for the full fee. Appointment rescheduling will be at the discretion of the clinician.

Insurance Coverage: Insurance claims will be submitted for coverage, which may include outpatient treatment reports and diagnostic treatment summaries.

You are responsible for informing your clinician of any changes in your insurance information, including coverage changes. If you fail to inform your clinician of any changes, you may become responsible for payment in full for professional services.

You are responsible for the costs of professional services, regardless of coverage. By signing this form, you are authorizing insurance carriers to make payment directly to your provider. If your insurance carrier will only submit payment directly to the client, you are responsible for paying for services in full at the time rendered and seeking reimbursement from said insurance carrier.

Credit Card: Your credit card will be held confidential and only be charged the amount of the cancellation or missed appointment fee plus a $4.00 processing fee in the event that you cancel or miss an appointment: Type: MC V AE DIS
Name on card: _____ Expiration: _____

Account number: _____ Security Code:_____ Zipcode:_____

Acknowledgement and Agreement of Financial Practices and Fees:
I have read and understood the above stated policies and agreements with kTherapy / Brainspotting with Katherine.

_____ _____
Signature of Client/Legal Guardian Date
(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____
Witness Date