Breakthrough
Mental Health Counseling

Financial Policy & Review of Consent Agreement Please review this Financial Policy, which describes Alexis Cleckner’s schedule of fees for therapy services, charges not covered by insurance, and additional fees.

Please be sure you understand the policies regarding cancellations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. If you have any questions about anything, please ask Alexis Cleckner, LPC prior to signing this form.

Please initial after reading each statement below:

_________ I understand that Breakthrough Mental Health Counseling, PLLC will keep a credit card on file, in a secure online database. Your initials indicate you agree to have this card charged balance amount due.

_________ You will be expected to pay for each session in full at the time of services provided. Accepted methods of payment are cash or credit cards.

_________ When using insurance, you are expected to pay your co-pay/co-insurance at the time of service. If you have not yet met your deductible, you will be responsible for the full session fee.

_________ By signing this form, you are giving Alexis Cleckner, LPC permission to charge your credit card for any services that have not been paid within 15 days of billing.

_________ You are giving Alexis Cleckner, LPC permission to charge your card for late cancelation and no-show fees on the day of your appointment. Alexis Cleckner, LPC will notify you by email when she submits the charge

_________ You will be charged a **$50.00 late cancel fee** if you cancel your appointment less than 24 hours in advance of your scheduled appointment time. This charge will automatically be charged to the card on file.

_________ You will be charged a **$95.00 fee if you do not cancel** or do not show up to your scheduled appointment, or cancel your appointment within 2 hours of the set appointment time. This charge will automatically be charged to the card on file.

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Card on file:

Card Number: ____

Name on Card: _______________________________ Expiration Date: ______ CVC Code: _______

Billing address: _____________________________________ Credit Card Type: ______________

I have read, understand, and agree to the above conditions.

Client Signature ____ Date ____________

Your initials indicate that you agree with the following (initial each one that you agree with):

_______ Limits of Confidentiality (all shared information is confidential within the limits listed on my PDS.)

_______ Payment for Services (payments are due after each session)

_______ Insurance Reimbursement (you authorize me to bill your insurance company- if applicable

_______ Telephone Calls and Electronic Mail (you agree to telephone and email correspondence)

_______ Consent to Treatment (you are voluntarily participating in therapy)

_______ In case of an emergency, call 911.