

Counseling Services of Arizona

Heidi Quinlan LPC, LISAC
3048 E. Baseline Rd., Ste. 107
Mesa, AZ 85204

Today's Date: _____

Court Involved Financial Information and Agreement

Authorization for Debit/Credit Card Charges

I _____ understand that Counseling Services of Arizona PLLC requires to have my credit card or debit card information on file in order to receive services. Below is a list of services provided by Counseling Services of Arizona PLLC that may be charged to my card if the services are provided. If a different method of payment is preferred, payment will be taken care of at the time of services. If payment is not made at the time of service, the amount of the service will be charged to the credit or debit card.

Fee Schedule:

Initial Assessments/Intake Appointment (90 min.)	\$125.00/session
Therapeutic Intervention Office Visits (Retainer: \$1250)	\$125/hour
Court-Ordered Counseling	\$100/session
Co-Parenting Session (50-90 min.)	\$100.00-\$200.00/session
Focused Assessment (Retainer: \$1500)	\$150.00/session
Comprehensive Family Assessment (Retainer: \$1000)	\$150.00/session
Parenting Coordination (Retainer: \$1050)	\$150.00/session
Supervised Visitation	\$65.00/visit
Additional person in visit (w/ legal permission)	\$10/visit
Monitored Exchanges	\$35/visit
Therapeutic Supervised Visitation	\$75.00/session
Telephonic Consultation (Billed in 15 min. increments)	\$25.00/15 min.
Correspondence/Reports (Billed in 15 min. increments)	\$25.00/30 min.
Face-to-Face Meetings/Staffings (Billed in 15 min. increments)	\$25.00/15 min.
Attendance at court (Billed per hour)	\$100/hour
Returned Check Fee (per occurrence)	\$35.00/occurrence
Copies/Faxes received over 15 pages	\$0.25/page

**** If the other party is 100% responsible for the fees, CSA still needs your signature/payment info**

Name as it appears on the card: _____ Phone #: _____

Email Address: _____

Debit/Credit Card #: _____ Expiration Date: ____/____

CVV (CSC) # _____ (For MasterCard or Visa, it's the last three digits in the signature area on the back of your card. For American Express, it's the four digits on the front of the card.)

Billing Address: _____

Street Address	Apt #
_____	_____
City	State Zip Code

***See Page 2**

*Late Cancellations/Missed Appointments: If you are unable to keep an appointment, kindly notify the office as soon as possible. Late cancellations make it difficult to offer the appointment time to someone else. Therefore, missed appointments and cancellations made less than 24 hours in advance of the scheduled appointment will result in a charge for the time reserved to the account of the party canceling. The party missing/canceling or causing the appointment to be canceled is 100% responsible for the charges of the late cancellation or missed appointment. No portion is billed to the other party's account.

Caregiver/Parent Initial _____

Double - Billing/Retainer: In Family Court cases, we cannot become involved with double billing. Each parent/caregiver is responsible for their portion of the payment at the time of service as ordered by the Court. In the event that the adult accompanying a child is not a responsible party (e.g., grandparent, etc.), payment from the responsible party(ies) must be received in advance. In all court-ordered matters, the initial retainer is maintained for billing all charges other than sessions (e.g., telephone calls, letters, emails, file review, reports). ALL SESSIONS must be paid in advance or at the time of the session. When the matter is concluded, if there is any balance left in the retainer, that amount will be refunded to the responsible party.

Caregiver/Parent Initial _____

Courtesy or Second Party Payers: Please understand that the Client/Parent/Guardian is responsible for paying all fees. This office will allow a courtesy payer or a second party (i.e. adult parent paying for an adult child, church or other organization as payer, etc.) to pay for services. However, we will not discuss appointments or appointment schedules with courtesy payer because of confidentiality unless a Release of Information has been signed.

Caregiver/Parent Initial _____

Outstanding Balance: Any accounts with a balance outstanding longer than 30 days will accrue interest at the rate of no less than 10% per month. If necessary, this office will utilize the services of a collection agency where the client/parent/guardian is responsible for all fees associated with collection.

Caregiver/Parent Initial _____

****NOTE: Insurance benefits do not cover Court-Ordered services. This office does not provide insurance carriers with diagnostic codes or billing statements for reimbursement purposes.**

By my signature, I acknowledge reading and agreeing to the above financial terms.

Caregiver/Parent Printed Name

Caregiver/Parent Signature

Date