



## COST REDUCTION PROGRAM

Arcadia Counseling Center has established a cost reduction program for those whose annual gross family income is insufficient to pay the standard fees (as stated in the "ACC Fee Agreement"). The program is based upon the following sliding scale:

<u>Gross Family Income</u>	<u>Appointment Fee</u>	<u>Initials</u>
Less than \$35,000- - - - -	\$140.00	_____
\$35-55,000- - - - -	\$150.00	_____
\$56-75,000- - - - -	\$160.00	_____
\$76,000 and over- - - - -	\$170.00	_____

If you meet the criteria for fee reduction based upon this scale, *please circle the counseling fee for which you qualify and initial to the right*; this affirms the fee that you will pay per session. Otherwise, the standard fee will be charged for each counseling service provided (as outlined in the "ACC Fee Agreement").

### CANCELLATION POLICY

**Cancellation of a previously scheduled appointment requires 24-hour notice.**

If advanced notice is not given, the client will be responsible to pay the full amount for the missed appointment. All appointments are booked exclusively. "No-shows" or "forgotten" appointments will also result in the client being responsible for full payment as it prevents openings for other clients. A "No-show" fee of \$50 will apply to intakes.

**Initial:** \_\_\_\_\_

### INSURANCE REIMBURSEMENT

ACC can provide you with a receipt in the form of a superbill for your insurance reimbursement (monthly, quarterly, or annually); the fee amount, a diagnosis code, our tax ID, and clinician information will be included. It is **NOT** our responsibility to file claims on your behalf, or to confirm whether your insurance company will reimburse you out of network services. We recommend that you contact your insurance carrier directly to inquire about services covered, the number of sessions covered, and the turn-around time for reimbursement. If using a Health Savings Account (otherwise known as HSA card), please make sure funds are available at the time of billing.

**Initial:** \_\_\_\_\_

\_\_\_\_\_  
Client/Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Arcadia Counseling Center, LLC

\_\_\_\_\_  
Date