Hicks Counseling Services

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FEE SCHEDULE

All co-pays and out-of-pocket payments must be paid at the time of service. If you are unable to come with your child to attend therapy please send them with the appropriate payment.

Clients are responsible for contacting their insurance company to obtain authorization, co-pay, deductible and benefit period information. Please provide this information with a copy of the front and back of your insurance card by faxing it to (866) 594-1848 or bring it at the time of your visit. If you have questions regarding in-network or out-of-network outpatient mental health benefits, please call your insurance company.

For your convenience, we accept MasterCard, Visa, Discover or checks.

Initial Evaluation	$160
Individual Psychotherapy	$145
Family /Conjoint Psychotherapy	$145
Support Group	$60
Life Coaching	$100
Legal Services	$500/hour* Plus $150/day for being on-call for court consultation.
Form Completion/Letter Writing	$160/hour**
Phone Consultation	$40/15 min. increments***
Supervision	$100/hour

*Legal Services are NOT performed unless required by subpoena. Court appearances, depositions, phone calls with attorneys and records required are included in this fee. This service is not billable to your insurance company and must be paid out of pocket before services are rendered.

**This includes recommendation letters, forms for schools, disability forms, and letters to employers. This service is not billable to your insurance company and must be paid out of pocket.

***In special situations clients may schedule a phone session or consultation. These situations are billed as a regular psychotherapy session and are billed to insurance. Out-of-pocket phone consultation fees apply when the client does not have a scheduled phone session but requests a phone call on ANY topic other than appointment scheduling. Such time is not billable to your insurance company.

If you are unable to attend your scheduled session and do not cancel within the 2-business day cancellation period you will be charged $75 which is NOT billable to your insurance company. Please sign below indicating you have read and agree to pay the above fees for services.

Printed Name: _____

Signature: _____ Date: _____

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