TESKE & ASSOCIATES, INC.
RAYMOND H. TESKE, LCSW
FEE AGREEMENT

I understand that the fee for a 50 minute psychotherapy session is $140.00, and that Raymond H. Teske, LCSW (hereinafter referred to as "Provider") will submit fees for my covered psychotherapy services to my managed care company, insurance company or Employee Assistance Program (EAP), as long as Provider is a listed provider with such company. I agree to allow Provider to file insurance claims on my behalf. _____
initial

I understand it is my responsibility to understand my coverage and benefits, including pre-certifications, referral and authorization requirements, and to be sure all insurance information on file with Provider is current. I further understand that my insurance is a contract between me, my employer and my insurance company to which Provider is not a party. As a mental health care professional, Provider's relationship is with me, not my insurance company. _____
initial

I also understand that should I choose to use my insurance, Provider must assign a clinical diagnosis to my claim to prove that my therapy or treatment is medically necessary. (This includes couples therapy and marriage counseling). This diagnosis becomes part of my record in central insurance computers. I understand that some patients choose to pay out-of-pocket for their therapy sessions in order to avoid possibly jeopardizing their future ability to obtain life, individual health, or disability insurance. _____
initial

I am also aware that Provider's contact with my health insurance company requires Provider to supply information relevant to the services that Provider supplies to me. Besides providing a medical diagnosis and code, Provider may be required to supply additional clinical information such as treatment plans or summaries, or copies of my entire Clinical Record. If asked for more information by the insurance company, Provider will make every effort to release only the minimum information about me that is necessary for the purpose requested. Provider has no control over what insurance companies do with my information once it is in their hands, although they are required to keep the information confidential. By signing this Agreement, I agree that Provider can supply requested information to my insurance carrier. _____
initial

I am responsible for any co-payment required through my managed care or insurance company, and shall pay such co-payment to Provider at each session with exact cash or check. I understand that if the co-payment is not paid at each session and it becomes necessary for Provider to bill for the co-payment, I will incur a $40 fee for each such billing. I further understand that returned checks will incur a $25 fee, in addition to any fees charged by Provider's bank, and will be posted to my account. _____
initial

I further understand that if my managed care company, insurance company or Employee Assistance Program (EAP) denies payment for services rendered, or makes it impossible to collect such payment in a timely manner, it will become necessary for me to pay my account in full. I also understand that any unpaid balance at the end of Provider's service will be sent to Collections unless alternative payment arrangements are made with Provider. _____
initial

I further understand that should I become involved in any legal proceedings that require the participation of Provider, I will be required to pay for all of Provider's professional time, including any and all preparation, transportation and attendance costs incurred by Provider. Preparation time for such legal proceeding will be billed at $200 per hour, and transportation to and attendance at such legal proceeding billed at $350 per hour. _____
initial

Cancellations of appointments must be made 24 hours in advance. I understand that I am responsible for full payment of any appointments not cancelled as required, knowing that missed appointments are not eligible for payment by insurance companies. _____
initial

_____
Client signature

_____
Client printed name

_____
Date