THE CENTER FOR
COGNITIVE THERAPY

REGISTRATION POLICIES AND FINANCIAL AGREEMENT

Fee for Psychotherapy (45-50 min):

The fee for a standard 45–50-minute psychotherapy session with **Dr. April Simcox** is **$250**.

_____ _____

Initials Date

Other Fees

As part of you or your child's care, your therapist may recommend supplemental services in support of treatment. All services will be prorated based on your therapist's psychotherapy fee listed above should you consent to your therapist's engagement in these additional offerings. The prorated amount will be calculated based on the time spent engaging in these services. Such services may include, but are not limited to:

- School Consultation/ IEP Meeting Participation
- Psychiatric Consultation
- In-School Observation
- Extended Sessions (either 60 or 90 minutes)
- Report Preparation

*All school consultations and off-site meeting include time spent at location + travel time to and from (based on Alexandria or Falls Church office location).

Case Management Fees

Phone contact more than 10 minutes is billed at a prorated fee based on therapist's rate. Phone contact includes communication with client, schools, other providers, etc. Additionally, staff will spend up to 30 minutes communicating with your insurance company at no charge. This time includes phone time, paperwork, etc. Any extra time is billed based on therapist's rate.

Payment

I understand that payment in full is required at each visit. Payment may be made by check, cash or credit. I understand and agree that I am charged directly and am personally responsible for payment of all services rendered to me (or the minor for whom I am responsible). I understand that the fee for returned checks is $30. I agree that if I default on payment, I will pay collections costs, attorney fees, and all court costs resulting.

Cancellations

I understand that I will be charged the full fee for any appointment missed or cancelled without giving 48-hour notice. CCTA generally allows for one "free" cancellation per client per year. I understand that my insurance company will not reimburse costs incurred from an appointment missed or cancelled without sufficient notice.

Insurance

I understand that the Center for Cognitive Therapy and Assessment does not participate with any health insurance plans. I understand that I am responsible for submitting claims for reimbursement with my insurance carrier. I understand that some procedures such as, but limited to, missed or late appointments, preparation of reports, and telephone consultations may not be reimbursable by an insurance company and are solely my responsibility.

Billing/Invoices

I understand that invoices will be mailed or delivered to me on a monthly basis. Please keep your invoices. Requests for replacement of invoices or itemized bills will be subject to a $15.00 charge.

Responsibility

I have read and agree to the above information. My signature below indicates that I both understand and agree to these policies.

_____ _____

Name and Signature of Responsible Party Date