



C. Blair Skinner, M.S.
Licensed Marriage and Family Therapist

2095 W. 6th Avenue Ste 212; Broomfield, CO 80020
 (720) 980-4034

Fee Schedule and Contract

Payment for services is an important part of any professional relationship. Co-payments and fees must be paid at the time of each session. Please feel free to discuss any questions or concerns you have regarding our fee agreement with me at any time. Sessions must be cancelled with 24-hour notice to avoid being charged for the session. You will be charged 50% (50.00) for missing a session, or canceling less than 24-hours in advance.

Therapy services \$100 per therapeutic hour (45-50 minutes).

Providing comprehensive service to you and your family is important to me, and sometimes requires work above and beyond the therapy hour. This could include phone calls or consultations with outside providers, letters written at your request, and court testimony. Fees for these services are listed below. Insurance typically does not cover these services.

Additional Services	Fees
School visits, attending meetings at your request (including travel)	\$100 per hour
Legal work (including phone testimony &/or travel time)	\$200 per hour
Letter writing	\$100 per hour
<i>While there is no charge for phone calls or e-mails to check-in briefly or to discuss scheduling, phone calls or e-mails requiring review or response taking 10 minutes or more will be billed as follows:</i>	
Phone calls/e-mails (over 10 minutes)	\$100 per hour

Primary Insurance Information: Please attach a copy of insurance card (front and back)

Insurer's Relationship to Client: () Self () Spouse () Dependent () Parent / Guardian () Other		Insured DOB
Name of Insured		Insured's SSN
Insurance Company Name		Insurance Phone Number
Policy Number	Group Number	Authorization Number (if required)

I, the undersigned, agree to a fee of _____ per session, or if I am using my insurance, I agree to pay a co-pay of _____. There will be an interest fee of up to 1.5% per month (18% per year) applied to balances after 30 days. It is understood that client fees not paid in a timely manner will be forwarded to collections, and you will be responsible for any collection fees incurred. Checks returned for insufficient funds will be charged a \$30 processing fee. If preauthorization is required by my medical insurance for therapy, it is my responsibility to obtain this, even before the first visit. Should your insurance company fail to pay for services, you will be responsible for fees incurred at the above rates.

My signature below indicates my agreement to pay all fees as outlined by this contract.

 Signature of client/parent/guarantor

 Printed name of client/parent/guarantor

 Date

 Date