

JULIA WALL, M.ED., L.P.C.

FEE SCHEDULE

The following is a list of fees for various services offered by my practice. If any portion of these fees is not payable by your insurance, you will be responsible for the balance at the time service is rendered. Please review and sign below indicating your understanding and acceptance of this fee schedule.

Individual Therapy (50 min)	\$110
Marital/Family Therapy (50 min)	\$160
(90 min)	\$200
Parent Consultation (half session)	\$55
Play Therapy (50 min)	\$160
Emergency Calls (Rate charged per half hour)	\$75
Phone/Email Consultations (Rate charged per half hour)	\$50
Court Appearances (Charged per day of appearance, plus hourly rate for preparation time. 1/2 nonrefundable if cancelled with less than 48 hours' notice.)	\$800
Office Reports/Letters/Forms (Rate for Preparation)	\$50

No Show/Cancellation
(Without 24 hrs notice)

Full Session Fee
(Please note insurance WILL NOT cover this charge)

I understand I am ultimately responsible for payment of all professional fees, regardless of whether or not my insurance company reimburses for the services.

Client/Guarantor Signature

Date

734 E. Corsicana Street
Suite B
Athens, TX 75751
Ph. 936-727-0393

JULIA WALL, M.ED., L.P.C.

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice. A credit card number will be held on file and charged to all clients who do not show up for or cancel an appointment with less than 24-hour notice.

Thank you for your cooperation regarding this important matter.

Client Signature (Client's Parent/Guardian if under 18)

Today's Date

TO BE USED ONLY FOR NO SHOW, LATE CANCELLATION, PHONE CALL &/OR EMAIL CORRESPONDENCE

Credit Card Type: Visa ____ Mastercard ____ Discover ____

Credit Card Number: _____

Exp. Date: _____ CVC Code: _____

Billing Zip Code: _____

Name on Card: _____

Signature

Date

734 E. Corsicana Street
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JULIA WALL, M.ED., L.P.C.

Financially Responsible Party/Guarantor Information

Guarantor Name: _____ D.O.B. _____

Guarantor Address: _____

Home Phone: _____ Work/Cell Phone: _____

SSN: _____ Relation to Pt.: _____

Guarantor Employer: _____ Work Phone: _____

Guarantor Occupation: _____

Insurance Company Name/Phone Number: _____

Member ID/Policy Number: _____ Group Number: _____

Assignment of Benefits: I authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical benefits directly to Julia D. Wall, M.Ed., Licensed Professional Counselor, for the services provided.

Client/Guarantor Signature _____

Date _____

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