Kimberly Hinrichs, LCSW, PLLC
6933 W Emerald St
Boise, ID 83704

Payment Agreement for Services

Name(s): _____

Address: _____

City: _____State: _____Zip: _____ Phone:_____

Bill to:
Person responsible for payment of account:_____

Address: _____

City: _____State: _____Zip: _____ Phone:_____

Employer:_____ Phone:_____

I/we agree to pay Kimberly Hinrichs, LCSW, PLLC for services rendered based on the Fee Schedule identified below:

Fee Schedule:

- **45 minute** scheduled counseling sessions will be charged at $110 for individual and $120 for couples.
- **55 minute** scheduled counseling sessions will be charged $120 for individual and $140 for couples.
- **50 minute Family Therapy w/client present** will be charged at $140.
- **30 minute** scheduled counseling sessions will be charged $55 for individual and $60 for couples.
- Sessions scheduled for longer than 80 minutes will incur further additional fees.
- **Psychiatric Evaluations** will be charged at $150.
- Any additional recommendation letters or development of treatment documentation requested by client beyond what is required for insurance billing will result in additional charges based on hourly fee.
- **Phone consultations** lasting longer than 15 minutes will also incur a fee of (discretion of the therapist) $25 per 15 minutes (i.e. 30 minutes on the phone will be $25) to be **paid at the next session.**
- If subpoenaed to court to testify on your behalf, Kimberly Hinrichs, LCSW, PLLC will charge $500 flat fee, to cover travel time, to and from the office, as well as time spent in court. This is not covered by insurance and will be an out of pocket expense.

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Kimberly Hinrichs, LCSW, PLLC is an approved provider for several insurance companies and will bill insurance directly for clients with health benefits. Kimberly Hinrichs, LMSW, PLLC is contracted with Rose Gold Solutions, LLC phone# 208-205-9186 to provide insurance billing and account management services. Only the minimal required information necessary to submit insurance billing and account management services will be provided to Rose Gold Solutions, LLC. All agents of Rose Gold Solutions, LLC are subject to the same privacy policy rules and regulations established by HIPAA secured under the Business Associate Contract between the billing agency and Kimberly Hinrichs, LCSW, PLLC.

The Person Responsible for Payment of Account shall make payment for services that are not paid by your insurance policy, all co-payments, and deductibles. Kimberly Hinrichs, LCSW, PLLC will also attempt to verify these amounts with the insurance company. Your insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary, or ineligible (not covered by your policy, or the policy has expired or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in the fee schedule above.

Payments, co-payments, and deductible amounts are due at the time of service.

I HEREBY CERTIFY that I have read and agree to these conditions

Person responsible for account: _____

Date: _____/_____/_____

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RELEASE OF INFORMATION AUTHORIZATION TO THIRD PARTY

I/we authorize Kimberly Hinrichs, LCSW, PLLC or her billing agent Rose Gold Solutions, LLC to disclose case records (diagnosis, treatment plan, psychological reports, testing results, or other requested material) to my (our) insurance company for the purpose of receiving payment directly to Kimberly Hinrichs, LCSW, PLLC.

I/we understand that access to this information will be limited to determining insurance benefits and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. **I/we** understand that **I/we** may revoke this consent at any time by providing written notice, and after one year this consent expires. **I/we** have been informed what information will be given, its purpose, and who will receive it. **I/we** certify that **I/we** have read and agree to the conditions and have received a copy of this form.

Responsible party: _____ Date: __/___/____

Person(s) receiving services: _____ Date: __/___/____

Person(s) or guardian(s): _____ Date: __/___/____

A copy of this form is available for your personal records (circle one):

Yes, I would like to receive a copy No, I do not want a copy at this time