RACHEL M. LOUDEN, LCSW, INC.
LICENSED CLINICAL SOCIAL WORKER # 992130
4900 CHERRY CREEK SOUTH DRIVE
SUITE 6
DENVER, CO 80246
(303) 629-6399

Financial Policy

Dear Client:

Thank your for choosing me as your psychotherapist. The following is a statement of my Financial Policy, which I require that you read, agree to and sign prior to our first session. **Please understand that payment of your sessions is part of your treatment.**

1. You are responsible for all fees in full. They should be paid for before the start of treatment at the beginning of the session. I ask that you pay at the time of service unless other arrangements have been made.
2. Acceptable methods of payment are check and cash.
3. Cancellation of appointment must be made one business day in advance or you will be charged for the missed appointment. **If your session falls on a Monday you must cancel on by the previous Friday in order not to be charged**.
4. **Insurance**: I will provide all the necessary information on your Client Invoice or HCFA so you may submit to the insurance company for possible reimbursement. You will be responsible for full payment of fees. The insurance company will reimburse you according to their schedules.

   It is up to **you** to investigate your insurance's benefits and reimbursement schedules. Dealing with insurance companies can be confusing and time consuming. Benefits may change over time and you must remain vigilant about your current deductible and reimbursement rates. Insurance companies may deny or delay payment even when the paperwork is in order and submitted properly. This requires re-submission of your receipts sometimes. Make sure to keep copies of my Client Invoices or HCFAs in case you need to repeatedly resubmit them.

   If you plan to submit receipts to your insurance company for possible reimbursement please provide a copy (front and back) of your insurance card. This will allow me to complete your receipts with all the necessary information in order for you to attempt reimbursement.

   5) Should you not pay your bill in a timely manner, I reserve the right to send your account to a collection agency. The collection agency will only receive information relevant to collecting your fees and no information regarding the content of your therapy will be released.

Plase indicate that you have read and understand this information. ____initials

The fee charged per session will be ___________ per 50-minute session. If you require a longer session you will be charged proportionately.

If you have any questions about this policy, please contact me immediately.

I have read, understand and agree to the provisions of this Financial Policy of Rachel M. Louden, LCSW

Client Signature____________________________________ Date:_______

Rachel Louden, LCSW_______________________________ Date:______