Rhonda **Andrews** LCSW
Individual, Child & Family Therapist

307 East Second Street, Suite 155 // Newberg, Oregon 97132 // **503.554.6655** // **rhondaandrewslcsw.com**

FEE AGREEMENT

The fee per session with Rhonda Andrews, LCSW is $95.00. Co-pays and/or deductibles are due at each session.

Rhonda Andrews will abide by the rates set forth in her contract with your insurance company. Therefore, the above rate may be less if applicable.

By signing below, I am agreeing to abide by the fee as stated in the above notice. I understand that by signing this form that I am agreeing to accept Rhonda's fee as applicable to any agreement she may have with my insurance. If I do not carry insurance at any given time and/or part or whole is not covered or paid by insurance, I hold myself responsible for the full fee, or portion not paid by insurance, as set forth in the above agreement.

Special arrangements if different from the above are as follows:

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_____.

No Show Fee: A $30.00 fee will be charged for all "no-show" missed appointments. However, the first no-show appointment per calendar year (Jan. 1 – Dec. 31) will remain at no charge. If you need to cancel or reschedule an appointment, I ask that you call me at the office once you are aware that you are unable to come to your appointment, preferably 24 hours in advanced. If you do not notify me prior to the time of the appointment, then it is considered a no-show.

Returned Check Fee: A $25.00 fee will be charged for a returned check.

Telephone Calls, Messages, E-mails: Telephone consultations with you, the client, will continue to be at no charge. However, any scheduled telephone calls with collateral contacts, such as other professionals, will be charged at $30.00 per hour if the call exceeds fifteen minutes. I encourage parents to send me an e-mail, or call me and leave a message, 24 hours before the appointment, to update me on the child/family situation. I cannot guarantee the confidentiality of e-mails. E-mails are not to be used for emergencies, I can only guarantee that I look at e-mails during my working hours.

School Visits/Meetings: Sometimes it is very beneficial for me to attend a meeting at school, or observe your child at school. There will be a fee of $.50 per mile for traveling to the school. The mileage count begins at the office address above. The regular per session fee applies as well. These visits usually cannot be billed to your insurance. I will not participate in a meeting or do an observation, without prior notice and agreement with you.

Home Visits: Regarding home visits, there will be a fee of $.50 per mile. The mileage count begins at the office address above. The regular per session fee, applies as well.

Litigation: My hourly fee for litigation (court work) is $85.00 per hour. My litigation rate applies to preparation time, travel time, conferences with attorneys or experts, waiting time, and testimony time.

If I am given a subpoena, for my attendance in a court hearing, a four-hour fee ($95.00 x 4) will be paid at the time the subpoena is issued, by the party who is issuing the subpoena. If I attend the court hearing, the party who issues the subpoena will pay my rate of $95.00 an hour for any preparation time, travel time, wait time, conferences with attorneys or experts, and testimony time that goes beyond 4 hours (that was paid at the time the subpoena was issued). If the court proceedings are cancelled, or I do not need to appear in court, I will refund the party for unused time. If I am provided less than 24 hours notice of cancellation of any proceedings for any reason, I will retain the full four-hour fee that was paid at the time of the subpoena.

In divorce situations, I will not make custody recommendations, or testify to custody decisions. I am not a custody evaluator, and will not act as such.

The client(s) who signed the fee agreement form is considered the responsible party and must pay the co-pay at the time of service.

By signing below, I am agreeing to the above policy as it is written and hold myself responsible for any fees arising from the above policy.

_____ _____

Name of Client Name of Responsible Party

_____ _____ _____

Signature of Responsible Party Date Therapist's Signature