FEES AGREEMENT

THE HOPE CENTER
206 South 28th Avenue
Hattiesburg, MS 39402
601-264-0890

1. **I, _____, understand that fees for services are as follows:**

Dr. Smallwood:		**Thomas Pough, MS, LPC, Ted Crawford, M.S. LMFT,**		**Ashley R. Sumrall, M.S.**
$175.00	**1 diagnostic hour**	**$155.00**	**1 diagnostic hour**	**$120.00**
$165.00	**1 hour**	**$145.00**	**1 hour**	**$110.00**
$149.00	**¾ hour**	**$131.00**	**¾ hour**	**$82.00**
$ 99.00	**½ hour**	**$ 87.00**	**½ hour**	**$55.00**
$ 50.00	**¼ hour**	**$ 44.00**	**¼ hour**	**$27.00**

2. **I understand that a therapeutic hour is <u>50 minutes</u>. This allows your therapist time to complete documentation and schedule your next appointment. This is standard practice in the mental health profession.**
3. **These fees apply to therapy sessions, telephone consultations, records review, consultations with lawyers and other professionals, and letter/report preparation.**
4. **I also understand that payment for outpatient services is DUE AT THE TIME SERVICES ARE RENDERED. I further understand that insurance is a method of reimbursement to me for my payment to the clinic and is not considered a substitute for payment. Should I wish to file insurance, I understand that I will be given the proper forms so that I may collect for covered services.**
5. **I hereby give my consent to release pertinent information (i.e., diagnosis codes, procedure codes, summary of treatment, etc.) to my insurance company or managed care company, should they request it.**
6. **I further understand that I will be charged full fee for any missed appointment should I fail to cancel my appointment at least one business day in advance (i.e., I must cancel Monday appointments by 5 p.m. the preceding Friday; and Tuesday through Friday appointments must be canceled 24 hours in advance). I also understand that I will be charged for any portion of time spent in therapy over my scheduled session length. In addition, any phone calls in excess of 15 minutes will be charged accordingly, at quarter-hour increments.**
7. **I am aware that some psychological testing may be necessary for treatment, and that fees for such testing are available upon request and will be discussed with me by my therapist.**
8. **I further understand that if my account should become delinquent, legal action for collection may be undertaken. I hereby give my consent to release necessary information, that is, name, address, account number, phone numbers, amount due, action taken to date, place of employment, for taking such action.**

Signature of client or legal guardian _____
Signature of witness _____
Date _____