Amy Sander Montanez, D.Min, LPC, LMFT
Personal and Family Growth Associates, Inc.

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POLICY, FEES, PAYMENT, INSURANCE AND SCHEDULING

The fee for services is $140.00 for 50-55 minutes. Please plan to pay the full fee after each session unless otherwise arranged in advance. You will not be billed. However, a copy of your charges and payment record will be made available upon your request. You may pay with cash, credit or debit card, or a check made out to PFGA (Personal and Family Growth Associates, Inc.)

Your appointment time is reserved for you alone. Without sufficient prior notice, it cannot be given to anyone else. **You will be charged the full fee for any missed appointments unless I receive cancellation notice 24 hours in advance or am advised in the event of an emergency.** Appointments will be scheduled after sessions or you can call the office manager at 803-254-5650,ext 201.

I do not file with insurance companies but will be glad to provide whatever information your particular plan requires so that you may file for reimbursement. (I do have a contract to file insurance for some professional groups. If you are in one of these groups, my office manager or I will have discussed this with you when you scheduled your first appointment.) Companies often require that a diagnosis be assigned before they will pay. If you find that this is necessary with your plan, I will advise you of my choice of a diagnosis for insurance purposes.

Insurance companies and policies differ greatly in their choices of what types of providers and mental services are covered. There are sometimes confusing and seemingly arbitrary restrictions on reimbursements. With your permission, I will attempt to provide to you whatever documentation of your services your company requires. If you are relying on your coverage to pay for therapy, you should get direct confirmation from the insurance company that they will pay out-of-network mental health benefits and what percentage they will reimburse. **You are responsible for the full fee at time of service.**

****Please be aware** that using insurance to cover mental health fees is an automatic Release of information to your insurance company.

I have read and understand this policy

Name_____

Signature_____ Date_____