1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654 Phone: (907) 357-6513 | Fax: (907) 357-6514

September 1, 2022 Fee Schedule

Olive Tree Counseling, Inc. Fees

| Initial Assessment | \$350.00 | No Call No Show | Service cost |
|---------------------------|----------|-----------------|--------------|
| Individual session 55 min | \$200.00 | Art Therapy | \$200.00 |
| Family session 55min | \$200.00 | Play Therapy | \$200.00 |
| Brief session 45 min | \$160.00 | | |

Olive Tree Counseling, Inc. Administrative / Court Fee Schedule:

Copies per page \$.50 Summary of Care Reports \$ 100.00

Court appearances are hourly

(Point to point) \$ 2000.00

I agree that I am responsible for fees of service provided by OTC. My insurance company may make payments on my account; however, under HIPAA guidelines, I understand that other persons—be it friend, spouse, or family—may not make payments on my behalf without necessary authorization in a RELEASE OF INFORMATION. I also understand that OTC reserves the right to change the Fee Schedule and Terms of Payment at any time, and I will be provided with the new Fee Schedule and Terms at the next applicable visit. I am aware that I may stop my treatment any time but will still be responsible for paying for services I have already received. Should I not comply with my responsibility to pay for services, OTC reserves the right to provide my demographic data and financial information to a collection agency.

Insurance Information

I understand that OTC will bill my primary insurance as a courtesy. I understand my insurance will be provided with personal information regarding services received at OTC. I have been informed and understand that OTC does not bill secondary insurance companies. However, I may request OTC to provide claim forms for me submit to secondary insurances myself. I understand that I will be responsible for fees not covered by my primary insurance. I request OTC to bill my insurance company for services I receive.

| for services I receive. | | |
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| No Call No Show I understand it is my responsibility to cand not cancel in advance and do not show up | cel an appointment at least 24 hours (1 day) before the time of J. I. will be charged for that appointment. | of the appointment. If I do |
| I,understand the Fee Schedule of OTC, and | (Name), acknowledge that I received a agree to comply with the terms listed above. | copy, thoroughly read, and |
| Printed name of Client | Signature of Client | Date |
| Signature of parent or guardian if applicable | Relationship to client (if necessary) | Date |
| Jody RossingHolly Hoff, LPC | Brittney Punt, LCSWDerek Sandlin, LPCDavid Banks, LPG | CKen Brewington, LPC |
| Printed name of Staff | Signature of Staff | Date |