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

Fees for Professional and Administrative Services

Olive Tree Counseling, Inc. Fees

Initial Assessment	$350.00	No Call No Show	Service cost
60-minute sessions	$200.00	Art Therapy	$220.00
45-minute sessions	$160.00	Play Therapy	$220.00
30-minute sessions	$100.00		

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.

No Call No Show

I understand it is my responsibility to cancel an appointment *before* the time of the appointment. If I do not cancel in advance and do not show up, I will be charged for that appointment. Late cancellations will be reviewed on a case-by-case basis. I acknowledge that I received a copy, thoroughly read, and understand the Fee Schedule of OTC, and agree to comply with the terms listed above.

My signature below shows that I understand and agree to the above terms.

Printed name of Client	Signature of Client	Date

Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date

_____Jody Rossing ____Holly Hoff, LPC _____Brittney Punt, LCSW ____Ken Brewington, LPC ___Keri Chandler, LPC

Printed name of Staff	Signature of Staff	Date