Eddie Windham, LCSW
1202 Common Street
Lake Charles, LA 70601
(337) 302-0801

GENERAL FEE AGREEMENT

Name of Client: _____ D.O.B.: _____

Fees and Policies for Services Provided by Eddie Windham, LCSW, are:

Initial Session	135.00
Individual, Family, Marital Sessions (30 minutes)	70.00
Individual Session 45-50 minutes	100.00
Individual Session 60 minutes	125.00
Couples/Family Sessions	135.00
Weekends or Holidays (50-60 minutes)	175.00
Substance Abuse Assessment	80.00
Domestic Violence/Anger Management Assessments	800.00 (includes report)
Weight Loss assessment & Report	250.00 (includes report)
Reports and Letters	35.00 per page
Clinical phone calls (billed in 15 minute increments)	35.00 per 15 minutes
Court Appearances/Depositions ($500 deposit required)	$150.00 per hour

Fee policies: Fees are applied for any services provided by Eddie Windham, LCSW in behalf of the above client. Additional fees not listed may also be applied for services related to the above client including, but not limited to, copying records, evaluations, attorney fees, collection fees, court preparation time, or other unforeseen fees beyond the customary services in providing direct therapy to the client.

Fees due: All fees are due at the time immediately before or after the services are rendered. Some special circumstances may allow for payment of fees to be postponed or may require a deposit in advance. Unpaid accounts may be turned over to a collection agency or filed with a district court.

Missed Appointments: Sessions **must be cancelled at least 24 hours prior to the scheduled appointment**. Clients who fail to keep their scheduled appointments and do not cancel 24 hours prior to the session **will be charged a $50.00 fee**. Calling and leaving a message on voice mail can cancel a session.

Insurance/third party payments: It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon. All proceeds of insurance are assigned to the therapist where applicable but without the therapist assuming responsibility for the collections thereof. You will be responsible for any services not covered or paid for by a third party including the payment of failed appointments, special requests, copies of records or consultations. I can file insurance for you.

Agreement for payment of fees: By signing below, I verify that I understand and agree to abide by the fee policies of Eddie Windham, LCSW. Furthermore, I agree to take full responsibility for the payment of services rendered and fees regarding the above client not paid for by a third party or by special arrangements. I hereby stipulate and agree to pay all costs of collections, attorneys, and court costs when necessary to collect fees regarding the above client.

_____ _____ ____/____/____
Signature of Responsible Party Witness Date

Eddie Windham, LCSW

1202 Common Street
Lake Charles, LA 70601

Date: _____/_____/_____

Identified Patient's
Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

Marital Status: _____ Social Security No.: _____

Name of Spouse: _____ Primary Insurance Co (Group & Policy No.):

Responsible Party: _____ _____
(If other than Identified Patient)
Address: _____ Phone: _____

If Patient is a child – Responsible Party's Social Security Number: _____

Employer: _____ Occupation: _____

Employer's Address: _____ Employer's Phone: _____

_____

Spouse Employer: _____ Occupation: _____

Employer's Address: _____ Employer's Phone: _____

_____

Referred by: _____

Emergency Contact: _____

Address: _____ Phone: _____

_____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I AUTHORIZE TREATMENT OF THE PERSON NAMED ABOVE AND AGREE TO PAY ALL FEES AND CHARGES FOR SUCH TREATMENT AT THE TIME OF TREATMENT. CHARGES SHOWN BY STATEMENTS ARE AGREED TO BE CORRECT AND REASONABLE UNLESS PROTESTED IN WRITING WITHIN THIRTY DAYS.

IT IS AGREED THAT PAYMENTS WILL NOT BE DELAYED OR WITHHELD BECAUSE OF ANY INSURANCE COVERAGE OR THE PENDENCY OF CLAIMS THEREON. ALL PROCEEDS OF INSURANCE ARE ASSIGNED TO THE THERAPIST WHERE APPLICABLE BUT WITHOUT THE THERAPIST ASSUMING RESPONSILITY FOR THE COLLECTIONS THEREOF. I AGREE TO PAY FOR INSURANCE INFORMATION REQUESTED IF ACCOMPANIED BY A SIGNED RELEASE OF INFORMATION FORM.

I AGREE TO PAY CHARGES FOR ALL APPOINTMENTS NOT KEPT UNLES CANCELLED 24 HOURS IN ADVANCE. I AGREE TO PAY CHARGES FOR TELEPHONE CALLS MADE AFTER REGULAR OFFICE HOURS.

Signature: _____ Date: _____/_____/_____

Responsible Party's
Signature: _____ Date: _____/_____/_____
(If other than Patient)