

# WILSON COUNSELING, LLC

## HEALTH INSURANCE INFORMATION

DATE: \_\_\_\_\_ NEW or UPDATED THERAPIST: \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_ GENDER: MALE/FEMALE

CLIENT DATE OF BIRTH: \_\_\_\_\_ CLIENT SSN: \_\_\_\_\_

IF OTHER THAN CLIENT, PERSON(S) RESPONSIBLE FOR ACCOUNT: \_\_\_\_\_

\_\_\_ I understand that each parent is equally responsible for payment of out-of-pocket expenses and that it is not the obligation of this agency to manage percentages.

CLIENT ADDRESS: \_\_\_\_\_  
Street City State Zip

PHONE: \_\_\_\_\_

EMAIL ADDRESS TO RECEIVE MONTHLY STATEMENTS: \_\_\_\_\_

\_\_\_ I understand it is my obligation to ensure current health insurance information has been provided and I hereby accept responsibility for amounts not covered by insurance.

**PRIMARY INSURANCE:** \_\_\_\_\_ MEMBER ID: \_\_\_\_\_

POLICY HOLDER'S NAME IF DIFFERENT THAN CLIENT: \_\_\_\_\_

POLICY HOLDER'S EMPLOYER: \_\_\_\_\_

POLICY HOLDER DATE OF BIRTH: \_\_\_\_\_ POLICY HOLDER SSN: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ MEMBER ID: \_\_\_\_\_

POLICY HOLDER'S NAME IF DIFFERENT THAN CLIENT: \_\_\_\_\_

POLICY HOLDER'S EMPLOYER: \_\_\_\_\_

POLICY HOLDER DATE OF BIRTH: \_\_\_\_\_ POLICY HOLDER SSN: \_\_\_\_\_

### CREDIT CARD AUTHORIZATION (optional)

I HEREBY GIVE CONSENT FOR THE FOLLOWING CREDIT/DEBIT CARD TO BE MAINTAINED ON FILE FOR CHARGES INCURRED AT WILSON COUNSELING.

Name as it appears on Credit Card: \_\_\_\_\_

Credit Card #: \_\_\_\_\_

Security Code: \_\_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_

Billing Zip Code: \_\_\_\_\_



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Identified Client: \_\_\_\_\_

**FEE SCHEDULE**

Welcome to Wilson Counseling. We appreciate the opportunity to help! All clinicians have a Master’s degree in a Social Work or Clinical Counseling. LCSW/LPCC’s have completed Board requirements and passed the full-level licensure exam for independent practice. CSW/LPCA’s have passed a mid-level licensure exam and are under supervision and working toward independent licensure. All clinicians are required to complete continuing education. Many of our clinicians are certified in a specialty or have sought additional training in specialized areas to enhance degree of expertise and skill. This amount of education, practice under supervision, written examination, licensure, and continuing education provide you with a highly qualified mental health professional. Licensure boards maintain a high standard for practice, and clinicians are ethically bound to uphold these standards.

**Mental Health or Substance Abuse Counseling**

Initial Assessment	\$175
Therapy session (52-60 minutes)	\$150

We are credentialed with most insurance companies and accept the negotiated rate of those companies. Your clinician must assign a diagnosis to be able to bill your insurance. Clinicians are assigned to clients with consideration of clinician’s ability to bill your insurance company. Not all clinicians can bill all insurances, so it is important to **report insurance changes immediately!** Client/parent will be responsible for charges not covered by insurance. Insurance claims will be submitted to primary and secondary insurances in the order the insurance companies require. Copays and amounts applied to deductible are due at the time of service. A late charge of 5% per month will be added monthly for any amounts more than 30 days past due from the date of invoicing.

**Supplemental/Support Services NOT Covered by Insurance**

** Co-Parenting services	\$150/hour
** Collaborative divorce coach services	\$175/hour
** Mediation services	\$175/hour
** Co-Parenting plan development	\$100/hour
** Couples Counseling	\$100-\$130/hour (dependent upon clinician)
** Consultation/email/text/file review	\$130/hour
** DUI 20-hour Education Class <sup>1</sup>	\$225
** DUI Workbook (required) <sup>1</sup>	\$25
** BIP Assessment <sup>1</sup>	\$75
** BIP Classes <sup>1</sup>	\$25/each

Bowling Green Office:  
1312 Westen Street  
Bowling Green, KY 42104

Russellville Office:  
252 N. Main Street  
Russellville, KY 42276

Voice: 270-904-1072

Fax: 270-904-1073



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**Court**

As an expert witness, significant preparation is necessary for court testimony or deposition. A subpoena compelling testimony is needed for records. A deposit of \$400 (1 hour of preparation and 1 hour of testimony) is due once subpoena is received. If testimony of more than an hour is anticipated, an estimate can be provided. The party issuing the subpoena or requesting a report will be responsible for fees. For any refund to be considered, 72 hours notice of court cancellation is required. An invoice can be provided upon request at any time. Notification will be sent to the court for unpaid fees over 60 days. **These services are not covered by insurance.**

- \*\* Court appearance-in person \$250/hour
- \*\* Court preparation (1-hour minimum) \$150/hour
- \*\* Court reports/consultations \$150/hour
- \*\* Court travel \$150/hour

**Missed Appointments**

Clinicians are hourly staff. Most often, clinicians have clients seeking appointments who must wait for an available time. For this reason, it is important that you make every effort to keep scheduled appointments or to provide adequate notice of need to cancel so that other clients may have access to that time slot.

24-hour notice of cancellation is required. A fee of \*\* \$25 will be charged for no-shows or less than 24-hour cancellation after the 2nd occurrence. These fees must be paid prior to scheduling another appointment. **These fees are not covered by insurance.** Persons with Medicaid will not be charged this fee, though clinicians may choose to transfer services to another agency.

**Records**

Clients are entitled to one free copy of medical records. Additional fulfillment of record requests beyond one free copy will be charged to the party making the request in 15-minute increments at \*\*\$130/hour. These fees are not covered by insurance. Please allow 10 days after making request.

**\*\* Indicates services NOT covered by insurance**

**<sup>1</sup> Due at the time of service**

I have read, understand, and agree to the above terms.

\_\_\_\_\_  
Client/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client/Guardian

\_\_\_\_\_  
Date

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