

The Power Path, LLC dba
OLUFEMI'S PROFESSIONAL COUNSELING SERVICES
FINANCIAL POLICY AND AGREEMENT
www.olufemis-counseling.com
powerpathllc@gmail.com
office (816) 665-3003 fax (913) 258-5495

Name: _____ Date: ____/____/____

Your credit card information will be kept on file for future billing purposes. This office accepts cash and major credit card and health insurance credit cards.

Insured Clients: Your health insurance carrier is billed on your behalf. The insurance EOB or (explanation of benefits) will determine the copay amount. The EOB arrives 2 to 3 weeks after claim submission. The full fee for service amount is required on your first visit; full fees are determined by your health insurance coverage. Credit cards on kept on file to charge for unpaid fees including late, same day and no show cancellations.

Uninsured Clients and Appointment Times: Uninsured clients are responsible for the full fee. Financial assistance is offered depending on the client's financial situation. Discounted fees have time limited sessions.

Two Day Cancellation Notice: A 48-hour cancellation notice is required for all scheduled appointments. Your credit card will be charged a cancellation fee for late, no show and same day cancellations that result in loss time for me. Cancellation fees vary from \$60 to \$75.00.

Late Arrival: All appointments are scheduled at the top of the hour. Fifteen minutes late for a scheduled appointment is considered a no show cancellation. A no show cancellation fee is charged to your credit card.

Online Scheduling: Online scheduling is available for client convenience; email confirmations and reminders are only a courtesy. Clients are encouraged to keep track of their scheduled appointments. A non-confirming response to the Yellow Schedule email confirmation request is not considered a cancellation. Please cancel on the Yellow Schedule application or contact the provider to cancel at (816) 665-3003.

Forms and Letters: a fee of \$75.00 to \$100.00 is charged for the completion of documentation to include but not restricted to FMLA, short-term disability packets, letters to employers, financial aid related, etc.

Session time fees: Fees for individual sessions \$130.00 (45 minutes in length). Fees for couple sessions \$150.00 (55 minutes in length). Fees for family sessions with 3 or more individuals \$170.00 (65 minutes in length).

Session over-time fees: Session time begins and ends on time. Over-time of ten minutes results in \$10.00. It is imperative for the provider to have a full break between sessions to re-balance and prepare for the next session. Please understand that running over the scheduled frame of time impedes that effort.

Health Insurance Coverage: We encourage clients to know their health insurance coverage before making an appointment. We submit claims electronically on your behalf and wait for the EOB to arrive in the mail or online. Fees and copays are collected at the time of service. Remember you are responsible for all charges not covered by your health insurance provider.

EAP Clients: An authorized number of sessions are free of charge unless it is a late, no show or same day cancellation at which point a cancellation fee will apply. A copy of the EAP authorization letter is presented to the Olufemi Sharp on the first day of service if not, the full fee is required until the EAP letter is provided. No refunds are made due to office accounting procedures.

Claims: adjustments in fees are made on your behalf once the EOB (explanation of benefits) is received from your health insurance carrier three to four weeks out from the electronic claim submission. Receipt of payments are issued upon request and sent electronically via email through Square payment processing.

I authorize my mental health provider, Olufemi Sharp to keep my signature on file and to automatically charge my debit or credit card for professional counseling services, prepared documentation, cancellation fees or any remaining balance due.

I have read and agree to comply with the payment conditions stated above.

Client Signature _____ Date ____/____/____

Provider _____ Date ____/____/____