MARYANN HUGHES COX, LCSW
5700 w grace street, suite 104, Richmond, VA 23226
Tel 359.2424 Fax 359.0029
www.maryanncoxlcsw.com

FEE AGREEMENT

I understand that Mary Ann Hughes Cox, LCSW will, as a courtesy, file claims for services rendered to my insurance company**. I UNDERSTAND THAT THE CO-PAYMENT IS DUE AT THE TIME SERVICES ARE PROVIDED.** ANY OTHER ARRANGEMENTS MUST BE NEGOTIATED AT THE FIRST SESSION. I understand I am responsible for advising Ms. Cox immediately of any changes to my insurance policy &/or address. I understand I am responsible for all fees for services rendered, regardless of the expected coverage of my insurance unless other arrangements are made. If pre-authorization of service is required, I will make the necessary arrangements to obtain this authorization.

I agree to provide 24-hour notice of a cancellation of a scheduled appointment or to pay for the missed appointment. Such charges will not be billed to the insurance company. THE FEE FOR MISSED APPOINTMENTS AND APPOINTMENTS NOT CANCELLED WITH 24 HOUR NOTICE IS $75. The fee is due at the next visit.

Every effort is made to obtain reimbursement through insurance. However, it remains my full responsibility to assume the financial obligation should the insurance company deny any part of the claim for services. Accounts are considered past due if no payments have been made for 60 days. All accounts are to be paid in full six months after the end of services, unless other arrangements have been made. If it is necessary to pursue collection of accounts through the courts or a collection agency, I understand that I will be responsible for payment of collections fees, attorney fees and court costs, as well as the overdue amount. There will be a $25. fee for all checks returned for non-payment.

The fee for the initial evaluation is $130. The fee for individual &/or couples' sessions is $110. Sessions are 55-60 minutes in length.

I assign my rights and benefits paid by my insurance company to be payable to Maryann Cox, LCSW under my policy for the professional or medical expense allowable and otherwise payable to me. I authorize the release of any information pertinent to my case to my insurance company.

I authorize the release of any medical information necessary to process claims and authorize payment of benefits for services to Mary Ann Hughes Cox, LCSW.

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Signature of responsible party Date