Financial Policy

Milena Skollar, LCSW

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1) All payments should be made at the time of service. If special arrangements need to be made in unique situations (i.e., someone other than you pays your bill), you can be billed monthly. In these cases, a credit card will be held on file and charged if payment for the previous month is not paid by the 30th of the following month (for example: If Nov. bill is not paid by Dec. 30). If this is the case, please call me so I can store your credit card information. If monthly statements are not paid consistently, you will be asked to move to a time of service payment. ***Note: Credit cards will be securely stored through Therasoft Online.***

2) Beginning January 1, 2020, the late fee policy will be upheld without exception. The policy is part of the informed consent you signed when starting in the practice. It reads: ***If you are delinquent with payment, there will be a $25 late fee after 30 days, and assessed once a month thereafter until the bill is paid in full (unless special payment plans have been made and approved of in advance).*** **For payment plans, the $25/month fee will be added to the bill each month until the bill is paid off in full.**

3) The fee structure is as follows:

- $250 for 45-50 minutes (individual, couples or family therapy)
- $300 for extended sessions/75 minutes (individual, couples or family therapy)
- $375 for Discernment Counseling sessions
- $450 for Double sessions and Intake (90 minutes to 2 hours)
- ***Note: Special financial arrangements will be re-evaluated every 3 months.***

If you are not paying by cash or check, please fill out the payment form below. All credit card information is encrypted and protected using Therasoft Online.

Credit Card Type (Visa, MasterCard, etc.):

Number: Exp: Code:

Please contact Milena Skollar (information above) or Joe Caridi (billing representative) at joe@caridi.com with any billing questions or concerns. Signing this agreement also acknowledges permission for Mr. Caridi to handle financial information, for me to communicate with him, and/or for he or I to communicate with third-party payers about your account/services on your behalf. Signing signifies agreement to the financial policy above.

Client/Responsible party (please print and sign your name with date included):

Print Name: ____

Signature: ____

Date: _____________________________

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