Ephrat L. Lipton, ACSW, LCSW, BCD, CEDS ephratlipton@gmail.com (404) 202-0932

Financial Policy

1). All payments will be charged at time of service. If special arrangements need to be made in unique situations (ie: someone other than you pays your bill), you can be billed by credit card on file or in special circumstances, monthly bills can be sent. In these cases, a credit card will still 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 the November bill is not paid by Dec 30th). If monthly statements are not paid consistently, you will be asked to move to a time of service payment only. ***Note: credit cards will be securely stored through our EHR . There will be < 3% processing fee added to the balance.***

2). The late fee policy will be upheld without exception. The policy is part of the informed consent 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.*** **For payment plans, the $25/month fee will be added to the bill each month until the bill is paid off in full. This is the charge for carrying a balance. Also, failure to provide 24 hour notice for cancellation of sessions will result in full charge for that session no matter the reason.**

3). Fees may increase yearly by up to, but no more than 10%. The current fee structure is as follows:

$330 for 45-50 minutes (individual therapy)

$475 for 75 minutes (individual, couples and/or family therapy)

$600 for a double session (90-100 min individual, couples, and/or family) and/or initial assessment

Special Financial Arrangement (to be evaluated every 3 months):

_____

Credit Card Info: CC# _____ EXP:_____/_____

CVV_____ Zip Code:_____

Please contact Ephrat Lipton (information above) or Kim Frey (billing representative) at (678) 984-6722 or ephratlbilling@gmail.com with any billing questions or concerns. Signing this agreement also acknowledges permission for Kim to handle financial information regarding your care and for me to communicate with her and/or for her or I to communicate with third party payors about your account/services on your behalf. Signing signifies agreement to the financial policy above:

Client Name: _____ Date: _____

Printed name of responsible party _____ Relationship to client: _____

Signature of responsible party _____

Ephrat L. Lipton, ACSW, LCSW, BCD, CEDS