The Northwest Catholic Counseling Center
8383 N.E. Sandy Blvd., Suite 205
Portland, Oregon 97220
Phone: (503)253-0964

FEE POLICY

The Northwest Catholic Counseling Center's primary interest is to provide you with quality and affordable care. For counseling our fee is $160.00 for the first session and $140.00 thereafter. In the event of financial difficulty, your fee can be negotiated to an amount you are more comfortable paying. For this reason, we wish to clarify the following policy regarding your fee.

Your fee is due and payable at the time of each session. If payment is not made at the time of the counseling session, your balance is not to exceed 30 days. If your balance reaches four sessions, you will not be allowed to schedule additional sessions until there is some payment activity on your account. There is a $20.00 service charge for all returned checks.

As a courtesy, we will make every effort to bill your insurance company. You are responsible for your deductible as well as any remaining balance the insurance company does not pay. If an overpayment is made to your account from an insurance payment, your account will be credited.

If cancellation of your appointment is not received 24 hours in advance you will be charged $60.00 for your missed appointment. Insurance cannot be billed for missed appointments.
I agree to the following (check all that apply):

☐ Insurance Payments (EAP, HMO, etc.):
I understand and agree to pay $_____ as my co-pay for each session. Co-pays are based on your insurance benefits.

☐ Self-Pay: Counseling Session:
For the initial appointment, I agree to pay $_____. This is a one-time fee due at time of service.
For follow up appointments I agree to pay$_____. This is due at time of service.

☐ Third-Party Payer (insurance excluded). It has been arranged that:

Name: _____ Phone: (_____)_____
Address: _____
City: _____ State: _____ Zip:_____

I understand if they do not pay, I am responsible for the bill.

I HAVE READ THIS FEE POLICY AND AGREE TO PAY THE FEE NEGOTIATED AND WRITTEN ABOVE. I UNDERSTAND THAT, REGARDLESS OF MY INSURANCE COVERAGE, OR THIRD-PARTY PAYER, THAT I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT.

Client Signature Date