AGREEMENT OF UNDERSTANDING
OF THE POLICIES AND FEES FOR
Dr. GINA DANIEL, LCSW

Diagnostic Interview $190
Individual Session (53-60 min) $165
Family/Couple Session (53-60 min) $150

PAYMENT OF FEES
Payment of fee or accepted co-payment/co-insurance is expected at time of visit. VISA and MASTERCARD are accepted. Charges may apply for services other than direct patient care (e.g. requests for reports, telephone consults, and photocopies). Gina Daniel may file claims for the following insurance companies:

Highmark Blue Shield/ Capital Blue Cross

Every effort is made to resolve outstanding charges mutually with patients. However, delinquent, unpaid outstanding balances which are considered to be your responsibility may be referred to a Collection Agency. At that time, your outstanding balance will be charged an additional collections fee.

INSURANCE POLICY
I understand my insurer will be contacted to verify my behavioral health insurance benefits. I further understand that what is actually paid by the insurance company may be different from the information given. I agree to pay all fees to Gina Daniel LCSW that my policy specifies, once written information is received from my insurance carrier. If I see Gina Daniel as an out of network provider, it is my responsibility to pay Gina Daniel directly and submit the forms to my insurance company for reimbursement.

LEGAL PROCEEDINGS
I agree that Gina Daniel will NOT be asked by me, or any attorney that I hire, to provide testimony to the court, unless previously agreed upon. Such testimonies can damage the therapeutic relationship and may also expose confidential communications provided. I also understand that if I violate this agreement and legally insist on a testimony, I will be charged forensic rates ($250/hour) for ALL time involved and that these fees are NOT covered by my insurance.

CANCELLATION POLICY
It is required that the patient give 24-hour advanced notice of an appointment cancellation. If no notice is given for a canceled appointment, or if Gina Daniel receives an improper cancellation, **I am subject to a charge of $75.** It is my responsibility to remember the date and time of appointments.

CONFIDENTIALITY
Our services are confidential. Please refer to our Notice of Policies to Protect the Privacy of Your Health Information.

PARENTS ARE RESPONSIBLE FOR THE SUPERVISION OF THEIR CHILDREN AT ALL TIMES SO THAT SESSIONS ARE NOT DISRUPTED.

I have read the information above and understand its contents.

Signature: _____ Date: _____