shepard counseling services

SHEPARD COUNSELING SERVICES

FEE ASSESSMENT & AGREEMENT

Client Name: _____

Client Date of Birth: _____

Effective Date: _____

Provider Name: Rhea Zerr-Shepard Ed. S, LPC, NCC Provider Contact: 770-854-0452

___ I understand that my insurance will not be billed for any services rendered by Shepard Counseling Services.
___ I understand that payment for intake and/or therapy sessions is due at the closing of each session.
___I understand that payment will be assessed and agreed upon by the therapist and client based on a sliding scale prior to any services provided.
___I understand that the sliding scale fee will be determined based on client/guardian income.
___I agree to disclose with accuracy household income and will provide proof of household income prior to the first session; if this is not provided, the therapist has the right to cancel the session.
___I understand that fees for services will be assessed at intake.
___I understand that I will be charged in full if the scheduled session is not cancelled 24 hours prior to the date and time of the scheduled session.

Sliding Scale Fee Assessment

- Household income below $30,000: **$45 per 55 minute session**
- Household income between $30,000–$60,000: **$65 per 55 minute session**
- Household income above $60,000: **$85 per 55 minute session**
- In-home counseling will require an additional **$5 per session** for traveling purposes
- If subpoenaed and/or court ordered to testify in court, the client will pay **$100 per hour** that the counselor is called to be present for the purpose of the subpoena and/or court order

Final Fee Agreement: _____ / Session

Guardian Signature/Date:

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_____ _____

Therapist Signature/Date:

_____ _____

Good Faith Estimate (GFE) for Counseling Services

Client Rights:

- You have the right to receive a Good Faith Estimate explaining how much your health care will cost.
- The estimate provided here is an **estimate** and actual charges may vary.
- You have the right to ask your provider for a more detailed breakdown of the estimate.

Important Notes:

- This estimate is for services **provided outside of insurance coverage** (self-pay).
- The final cost may vary depending on the length or nature of therapy sessions.
- For changes to your treatment plan or services, we will update the estimate accordingly.

Acknowledgment:
I acknowledge that I have received this Good Faith Estimate from Shepard Counseling Services. I understand that this is an estimate and that the actual charges may differ.

Client's Signature: _____

Date: _____