

**April Betty, LPC**  
**2095 W. 6<sup>th</sup> Ave.**  
**Suite # 212**  
**Broomfield, CO 80020**  
**(720) 235-8665**

**FEE AGREEMENT**

Client Name: \_\_\_\_\_

FEE:           \$110.00 for a therapeutic hour (45-50 minutes)  
               \$150.00 for an extended session (80 minutes)

**RESPONSIBILITY FOR PAYMENT:**  
You are responsible for payment at the time of each session. Further sessions will not be scheduled if you are not current with your payment. If I am a provider for your insurance company, I am glad to bill them on your behalf. *However, it is ultimately your responsibility to know your coverage and benefits, and to be financially responsible for any claim your insurance company denies.*

**CANCELLATION POLICY:**  
Sessions must be cancelled with 24-hours advance notice to avoid being charged for the session. If you know you will be unable to keep an appointment, please notify the office as soon as possible so that others needing an appointment can be accommodated. Please note that victim compensation and insurance companies do not cover missed appointments, and you will be billed the full fee. **Please initial here to indicate you understand this policy \_\_\_\_\_.**

**ADDITIONAL FEES**  
Providing comprehensive service to you/your family is important to me, and sometimes requires work above and beyond the therapy hour. This could include phone calls or consultations with you or outside providers, letters written at your request, review of pertinent documents and/or legal/court involvement. Fees for these services are listed below.

<b>Additional Services</b>	<b>Fees</b>
Letter writing, meetings, reviewing reports, etc.	\$110 per hour
Legal work (anything involving court, testimony, travel)	\$200 per hour

*While there is no charge for telephone calls/emails to discuss scheduling, other phone calls and emails that take more than 2 minutes are billed at my normal fee of \$110 per therapeutic hour, or \$2.20 per minute.*

**I, the undersigned, have read and understand this agreement and agree to be responsible for the above listed fees.**

**Client Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_