	Standard Rate (up to 60 minute increments)
New Client Evaluation	$75
Individual, Couples, Family	$75
Group per person	$35
Gottman Relationship Checkup	$29/couple for Assessment Only

Initial Phone, Email, Video Consultation is Free (Up to 15 minutes)

We accept the following Health Insurance: Tricare/Humana Military, Aetna, Magellan, Florida Blue, New Directions, Cascade, E4Health EAP. (We not accept any MEDICARE or MEDICAID) Please complete the Insurance Authorization section.

Super Bill Receipts are available for you if you choose to file Out of Network for insurance reimbursement.

**Sliding Fee Scale available based on Federal Guidelines. (See chart)

**Discounts are available for Active Duty Military, Veterans and their families; Seniors; Police, Fire Fighter, EMS Personnel and their families; PreK-12 Teachers; College Students. Other discounts may be considered on a case-by-case basis. We are accept referrals from Lutheran Social Services.

Discount Category: _____ Discount %: _____

*** Official Photo ID, Copy of Insurance Card (unless self-pay) and a Credit Card for billing are required to be on file for all clients.

Your Self-pay Rate $_____/Session **Your Co-pay $_____/Session**

Your Self-pay Rate $_____/Group **Your Co-pay $_____/Group**

Please note, if you owe a deductible you will be responsible for the full amount negotiated per contract with your Insurance Provider.

Signature	Date

(Client or Parent/Guardian if under 18) (Check ☐ if digital signature)

Print Client Name (First, MI, Last)

SLIDING FEE SCALE QUALIFICATION GUIDELINES

2019 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

*Proof of household income required.

Persons in family/household	Poverty guideline
1	$12,490
2	16,910
3	21,330
4	25,750
5	30,170
6	34,590
7	39,010
8	43,430

2019 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

For families/households with more than 8 persons, add $4,420 for each additional person.

Federal Poverty Level	Sliding Fee Rate – Individual, Couples, Family	Sliding Fee Rate – Workshop, Group
<100% FPL	$17.50	8.75
100 – 200% FPL	$35	17.50
200 – 300% FPL	$52.50	26.25
>300% FPL	$70	35

INSURANCE INFORMATION

Patient Name: _____ DOB:_____/_____/_____

Are you: Primary Insured?___ Spouse? ___Child? ___Other? ___

Primary Insurance Provider:	
Employer:	
If you are not the Primary Insured, ☐ *Print* Sponsors Name:	
Policy / Benefits No:	
Secondary Insurance Provider:	
Employer:	
If you are not the Primary Insured, ☐ P*rint* Sponsors Name:	
Policy / Benefits No:	

I understand I must provide proof of insurance and a photo ID for verification purposes.

I authorize the release of any medical or other information to process insurance claims. I authorize the payment of medical benefits to Maria Giuliana, LMHC Beyond The Matter Counseling and Consulting Services LLC, 3955 Riverside Ave, Jacksonville, FL 32205.

Signature:	Date:

☐ check and print name if you are authorizing a digital signature.

AGREEMENT TO PAY FOR TREATMENT CANCELLED AND MISSED APPOINTMENTS

If the cost of my treatment exceeds my benefits from my insurance company, to the full extent contractually allowed, I understand and agree that I am responsible for full and timely payment.

I agree to cancel appointments no less than twenty-four hours prior to the appointment time. If I do not give twenty-four hours' notice and another client does not fill my appointment time, I understand that I will be charged my regular fee.

Illness and other situations beyond my control will be given due consideration on a case-by-case basis.

Missed appointments or appointments cancelled with less than twenty-four hour notice are not covered by most insurance plans. If this is the case, I understand I will be personally responsible for payment at the self-pay rate. .

Signature:	Date:

☐ check and print name if you are authorizing a digital signature.

Client Name: