R.A.N Counseling
70 Woodfin Pl Suite 02
Asheville, North Carolina
28801
(828) 552-5260
rose@rancounseling.com

Election to self pay for services

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Thank you for choosing R.A.N. Counseling PLLC for care (“Provider”). We ask that you read and sign this form to acknowledge and agree to accept financial responsibility for services rendered by Provider to Client.

I acknowledge understanding and agreement of the following:

I understand that I have the option to use my health insurance benefits to pay for therapy services. However, I am choosing to pay out-of-pocket (self-pay) for services provided by Rose Neugroschel, LCSW at R.A.N. Counseling, PLLC (“Provider.”)

By signing below, I acknowledge and agree to the following:

- I am voluntarily choosing not to use my insurance benefits for therapy services, and I have freely chosen to self-pay for services after having asked Provider about payment options and having carefully considered those options.
- I understand that my Practice will not bill my insurance for services.
- I accept full financial responsibility for all fees associated with services received. As a courtesy, I have been offered a reduced self-pay rate for services. My current fees under this arrangement are:
  - Initial Intake Appointment (60 minutes): $150
  - Follow-Up Psychotherapy Sessions (45–60 minutes): $130 per session
- I understand that payment is due at the time of service unless otherwise agreed upon.
- I am aware that I may request a receipt (superbill) to submit to my insurance independently, but reimbursement is not guaranteed.
- I understand that choosing self-pay may mean that services will not count toward my deductible or out-of-pocket maximum.
- I understand I can revoke this decision in writing at any time, subject to practice policies.
- I understand that my Provider does not accept Medicare or Medical Assistance as insurance. I understand that Provider will not send claims to Medicare or Medical Assistance.
- I have read this form and had the opportunity to ask any questions I may have about it. Any questions I had about this form have been answered to my satisfaction.

- I understand that I will be responsible for paying a late cancellation fee for any appointment cancelled less than 48 hours prior to appointment start time (or for no show appointments). That fee is $100.

I acknowledge and agree that I am ultimately responsible for the payment to Provider for any and all services rendered by Provider to Client.

Client name:

Responsible party(ies) name:

Relationship to client:

☐ Responsible party's signature: I consent to sharing information provided here.