Safe Haven Child and Family Counseling Services, LLC
233 S. Sharon Amity Rd Ste 102, Charlotte, NC 28211
Office: 980-613-8474 Fax: 704-709-8580

Financial Policy

Self-Pay Rate: TBD
Initial Session: $250 -1 hour

Cancellation/ No-Show Policy:
Your appointment time is set aside solely for you; cancellations must be received **24 hours in advance of your appointment.** When 24-hour notice is not received, you will be assessed a **$50 late cancellation/no-show fee**. Please note insurance companies do not reimburse for cancellation fees.

We understand that life happens, and appointments may occasionally be missed. However, after **three (3) no-shows**, Safe Haven Child and Family Counseling Services reserves the right to terminate services. We will gladly provide referrals to alternative providers to support your continued care. This policy applies to all clients, including those with Medicaid coverage.

Good Faith Estimates:
In accordance with the No Surprises Act, Good Faith Estimates for services are available upon request. Please let us know if you would like a written estimate of the expected costs for your care.

Forms Completion (FMLA/Disability): $25 per event

Credit Card Authorization:

To streamline our billing and provide a more secure and efficient experience, we are implementing a payment policy:

- All clients with commercial insurance, Medicare, or those who pay out-of-pocket are required to have a credit card or healthcare flex spending card on file with us.
- It is your responsibility to ensure your card information and insurance details remain current.
- This policy will apply to all existing and new clients. As part of the onboarding process, new clients will be prompted to enter their card information before services begin.
- We are integrating our payment system through TherapyAppointment to ensure a secure and easy process.

Please note if your card is charged you will be notified of the amount charged and reason for the fee charged.

I understand the financial policy at Safe Haven Child and Family Counseling Services. I understand that I am responsible to terms of this policy as stated above.

Patient Name: _____

Patient Signature (Guardian): _____ Date: _____

Clinician Signature _____ Date: _____