

## **George W. Rinker, MS, MDiv.**

**Licensed Clinical Mental Health Counselor**

**5H2 Doctors Park  
417 Biltmore Avenue  
Asheville, NC 28801  
(404) 414-1465**

### **Fees and Financial Agreement (2025)**

Please read this document carefully. Your signature at the end of this agreement indicates that you have read it, understand and agree to make payments according to the terms outlined in this document.

The industry standard definition for a therapy session is a 50-minute session. This time frame allows the therapist to have time between sessions to write session notes and a short break before the next client. Therapist are paid for their time.

**Missed Appointments:** In the event that you are unable to keep a scheduled appointment, it is your responsibility to notify me with **no less than 24-hour notice** or you will be liable for the **full session fee of \$160**. If your appointment is scheduled for a Monday, you **must** cancel before Sunday or the \$160 fee applies. I collect payment and schedule your next appointment at the end of our 50-minute session. My fees for sessions and services are:

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| • <b>50-minute Session</b>   | <b>\$160</b>   |
| • <b>Letter Writing on your behalf</b>   | <b>\$95/30 minutes or \$160/50 minutes.</b>                      |
| • <b>Missed Appointment Fee</b>  | <b>Full Session Fee of scheduled session.</b>                    |
| • <b>Cancellation less than 24-hour</b>  | <b>Full Session Fee of scheduled session</b>                     |
| • <b>Telephone Consult with you or<br/>With a third party (MD, Psychiatrist,<br/>Other therapist, case worker, etc...)</b> | <b>No charge for first 10 minutes<br/>\$75/15 minutes after.</b> |
| • <b>Outside of session reading reports<br/>Assessments or other documents<br/>You or a third party send me.</b>           | <b>No charge for 10 minutes,<br/>\$75/15 minutes thereafter.</b> |
| • <b>Returned Check Fee</b>  | <b>\$35 or Bank Fee if higher.</b>                               |

**Payment:** You agree to pay the session fee in full at the end of each session as well as any other fees that are outstanding before another session may be scheduled. I accept a personal check, cash, Zelle or Venmo only. Please have the exact amount as I will not be able to provide change.

No credit cards are accepted. Checks are made out to: George W. Rinker, MS, LPC.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Insurance:** I do not work with insurance companies, except BCBS of NC. Insurance companies require a client be assigned a mental health disorder diagnosis in or to be reimbursed for counseling services. This mental health disorder designation becomes part of your permanent health record and can be accessed by current and future employers, the insurance industry and other such entities that deem it necessary to have your personal health record. If you want to assume the risk, I will provide you a receipt that you may submit for possible reimbursement as an out-of-pocket provider if that benefit is part of your plan. I do **not** call or correspond with your insurance company or provide additional paperwork other than a receipt. You are responsible for payment in full at the end of each scheduled session.

**For BCBS of NC Clients:**

BCBS of NC Clients: The only Insurance Company that is accepted in the practice of George W. Rinker, MDiv., MS, LPC is Blue Cross Blue Shield of NC.

**NOTE:** The provider will file a claim twice and after that if the claim remains unpaid the client is responsible for calling Blue Cross Insurance to find out why the claim is not paid. If Blue Cross fails to pay the client is liable for the \$160 rate for the unpaid session. Otherwise, Blue Cross is expected to pay the negotiated rate given the type of client policy. If it appears that BCBS continues to reject claims filed the counselor may opt to **not accept** the client's BCBS insurance due to not having the time to deal with BCBS.

The following information is needed in order to file your insurance in addition to a copy of the front of your Blue Cross Policy Card. Please fill out ALL data below.

Full Name of Insured: \_\_\_\_\_ DOB \_\_\_\_\_  
Insured: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group: \_\_\_\_\_  
My Home Address: \_\_\_\_\_  
My Phone: \_\_\_\_\_

Name of Primary Policy Holder: \_\_\_\_\_  
Primary DOB: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group: \_\_\_\_\_  
Primary HomeAddress: \_\_\_\_\_  
Primary's Phone: \_\_\_\_\_

**Agreement:** By signing below, you indicate that you have read, understand and agree to the terms and conditions outlined in this Financial Agreement document (2 pages). Your signature also indicates that you have had the opportunity to ask questions and/or discuss any concerns with me in the first, intake, session.

Client Name (Print): \_\_\_\_\_

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

