Real Life Therapy

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www.RealLifeTherapy.com

FEE AGREEMENT

Payments: Your fee for each 50-minute individual therapy session will be $_____. Your fee for each 50-minute initial assessment, Couples, & Family Therapy session will be $_____. You are expected to pay your session fee or insurance co pay at the start of each session unless other arrangements have been made. Patient is responsible for payment of the agreed upon fee (on a pro rata basis) for any telephone calls longer than ten minutes. Site visits, report writing and reading, consultation with other professionals, releases of information, reading records, longer sessions, travel time, etc. will be charged at $_____ per 60 minutes unless otherwise indicated and agreed upon. Accepted forms of payment are cash, check, or credit/debit card (Visa, MasterCard, Amer. Express or Discover). Credit/debit card information will be kept private other than by electronic means for billing.

Cancellation Policy: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 48 hours (2 day) notice is required to re-schedule or cancel an appointment. Clients are required to provide a credit card number which can be used for billing in the event of a late cancellation or no show. The **FULL** session fee will e charged to the credit card number provided in the section below for appointments missed without notice or canceled with less than 48 hours notice, **unless** we are able to find a mutually agreeable time to reschedule the appointment within the same week.

Credit/Debit Card Authorization: Per the terms of this Financial Agreement document, in the event of a late cancellation (less than 48 hours notice) or missed session, you will be charged the **FULL** session fee. Unless otherwise agreed to, the fee will be charged to the credit card account provided below.
I, _____, (client or caregiver/payer name if services are being paid for by someone other than client) am authorizing Real Life Therapy and its associated psychotherapist to charge the session fee of $_____ to the credit/debit card indicated below in the event that I (or the client if services are being paid for by a caregiver of other adult) do not attend a scheduled therapy appointment without giving a minimum of 48 hours notice and the missed appointment is not rescheduled and attended within the same week.

FEE WILL APPEAR ON CREDIT/DEBIT CARD STATEMENT AS "Real Life Therapy".
Card Type (circle one): Visa MasterCard American Express Discover
CC #_____
Name as printed on card: _____-
Billing zip code: _____Exp. Date: ____/_____ CVC (3 digit# on back): _____
Phone number associated with card: (___)_____-_____
Authorized cardholders signature:_____Date: _____/_____/_____
I have read the above Fee Agreement document carefully, and I understand it and agree to comply with all its terms and conditions:

_____ _____ _____/____/_____
Client Name (please print) Signature of Client Date