Agreement to Pay for Professional Services

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise. I accept cash, checks, and all major credit cards, but I prefer that you not use credit cards whenever possible as the credit card companies charge me a fee for each transaction. Payment schedules for other professional services will be agreed to when they are requested (for example, writing a letter for school, attending an IEP meeting, etc). If your account has not been paid for more than 60 days or there is an outstanding balance of more than $600 and arrangements for payment have not been agreed upon, my credit card on file will be charged and a receipt will be mailed or emailed to me at the address listed on my account.

Cohn Counseling has the option of using legal means to secure the payment. This may involve hiring a collection agency, and this could affect your credit. If such legal action is necessary, its costs will be included in the claim. There will be a $30 charge for the return of a check from the bank. Cohn Counseling is glad to give you a receipt to document your health spending for an FSA plan or for reimbursement through out-of-networker services.

Agreement

I request that the therapist named below provide professional services to me or to _____, who is my _____ , and I agree to pay this therapist's fee of $_____ for the initial evaluation and $_____ for 45 minute sessions and $_____ for 60 minute sessions for therapeutic services. Your payment is expected for each session at the time it is held, unless we agree otherwise. The use of a credit card will incur a $5.00 processing fee.

I agree to pay a fee, at the same rate of a session for clinically related phone calls in excess of 15 minutes. Your clinician will discuss the necessity of the phone call prior to, and will communicate with you the expectation of this call.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons may make payments on my (or this client's) account. I am aware that I am obligated to give 24 hours notice for cancellations and will be held financially responsible for the cost of the missed session if less than 24 hours notice is given, except for emergency situations (to be determined by the clinician). I am aware there will be a $30 charge for the return of a check from the bank.

Outstanding balances may result in a termination of treatment or the use of legal means to secure payment. This may mean hiring a collection agency or going to small claims court. Your clinician will always attempt to communicate with any client regarding the status of an unpaid balance prior to pursuing such actions.

I have also read this therapist's "Client Contract" brochure and agree to act according to everything stated there, as

shown by my signature below and on the brochure.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

Credit Card On File

Please provide credit card information below. By providing this importation it will simplify payment procedures in the event of a missed appointment without notice of cancellation, as well as occasions when an appointment is cancelled without 24 hours advanced notice. Credit cards will be charged if there is an unpaid outstanding balance for more than 60 days or an outstanding balance of $600. Your acceptance of this policy will ensure that your payments will always be up-to-date and will be made in a timely manner.

Name on card: _____

Billing Address: _____

_____

_____

___ Visa
___ MasterCard
___ Discover

Card # _____
Exp. Date _____ Security Code _____

Signature:_____ Date: _____

Your signature authorizes the billing of your card for services. This form will be kept in a secured and locked facility.