Payment Agreement

Professional Counseling Associates, LLC

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480-730-6222; 480-889-5566 fax

Please read the following and fill out the form completely. Once we have received your completed Payment Agreement, we will contact you to schedule further appointments.

- By completing and signing this Payment Agreement, you are indicating that you understand and agree to provide a valid credit card number, with expiration date, for payment of future therapy sessions, appointments, or other fees.
- Your signature indicates you understand that if you do not attend a scheduled appointment, your credit card will be charged the regular cost of the session you reserved unless you cancelled at least 24 hours in advance, business days – Monday through Friday; **for cancellations with less than 24 hours notice, the full fee will be charged**. For missed appointments with no notice given, the full fee will be charged.
- Your signature indicates you understand that you, not an insurance company or any other 3rd-party payer, will be paying for any missed or late cancelled appointments.
- Your credit card number will be kept on file throughout treatment and will be charged each time an appointment is missed without at least 24 hours advance notice. You can always call our office (24-hours a day) to leave a voicemail to cancel an appointment. However, please ensure that you cancel any appointments within the proper time frame to avoid credit card charges for missed appointments. Please know that we adhere strictly to the time requirements and Payment Agreement.
- Payments or co-payments are expected at the time of service or in advance of service. Your signature indicates you understand that if you do not pay with cash or check at the time of service (including phone or email consultation), your credit card will be charged for your payment due.
- Your signature indicates you understand you will be charged for all phone calls and email communication/consultation as indicated below, other than routine appointment scheduling, cancellation phone calls, questions regarding billing, or other administrative communications. If you do not wish to pay for such services, please schedule an appointment to instead come in and discuss your concerns. We will provide emergency services for current clients whenever possible.
- Your signature indicates you understand that your credit card may be charged for any fees or charges that your insurance company does not pay.

Current Fees for Services:

Initial Assessment/Evaluation – 50 minutes	$95.00
Individual Therapy – 50 minutes (regular session)	$95.00
Individual Therapy – 100 minutes	$190.00
Marital/Couples/Family Therapy – 50 minutes	$95.00
Marital/Couples/Family Therapy – 100 minutes	$190.00

I understand and agree to comply with this Payment Agreement. I authorize the use of my credit card information for payment of services rendered.

Client/Guardian:_____ Sign:_____Date:_____
Print Name Signature

Client Name:_____ SS# (or Insurance ID#):_____
If Different Than Above

Day Phone:_____ Evening Phone:_____ Cell Phone:_____

Please enter the following information exactly as it appears on your credit card statement:

Please Circle: VISA / MASTERCARD AMEX Card Number:_____

Expiration:_____ Card Verification Number:_____ Billing Zip Code:_____

Address:_____

*Your credit card information will be held confidential and this information will be secured in your client file.