A Family Works, Counseling PLLC

1760 E Boston St. Suite 102
Gilbert, AZ 85295
480.649.6499

CLIENT FINANCIAL AGREEMENT

Fees for services are charged at the following rates. Session duration is determined by your individual insurance policy:

Initial Evaluation	(45-60 Min.)	$180.00
Individual Psychotherapy	(45-60 Min.)	$180.00
Family & Marital Psychotherapy	(45-60 Min.)	$180.00
After hours and emergency appointments	(45-60 Min.)	$200.00
Court Testimony (including preparation and travel time)		$250.00 (per hour)

Unless other arrangements have been made in advance, full payment, or the appropriate co-pay, is to be **made at the time of the office visit.**

Other fees:	Report/Treatment Summary/Disability Forms/Letters	$50.00-$100.00
	No Show Fee	$75.00
	Late Cancellation Fee	$75.00
	Returned Check Fee	$36.00

Missed appointments, or appointments not cancelled with at least 24 hours notice, will incur a $75 fee. Insurance will not pay for missed appointments. If you fail to keep your appointment, fail to cancel more than 24 hours prior to the session, this block of time is no longer available to others and will incur a missed appointment or late cancellation fee that is the client's responsibility.

I authorize a $75 charge to my credit card if I fail to keep or cancel my appointment according to this agreement
I understand that my insurance will be billed on my behalf by this office, however, I remain legally responsible for all fees due to the therapist.
I authorize the release of my protected health information to my insurance provider to process my claims.
I authorize payment of medical/mental health benefits directly to A Family Works, Counseling PLLC.

Cardholder's Name: _____ CVV Code: _____

Credit Card #: _____ Expiration Date:_____

This form is required for us to be able to charge your credit card for the services rendered by A Family Works Counseling PLLC. This form ensures that we are doing all we can to avoid fraudulent charges to credit cards. By signing below, you witness that you have read and understand the above fees for services including no show and late cancellation fees. I authorize A Family Works Counseling PLLC to charge this credit card and hereby guarantee payment for services rendered.

_____ _____ _____

Client Name Signature of Client or Legal Representative Date

Please list all other client family members you authorize to use this card to pay for services rendered by A Family Works Counseling PLLC.

_____ _____ _____

_____ _____ _____