Christine Leonard LPC-A, LAC-A, NCACII, AADC, SAP, CS-IP
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AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I, the undersigned, request that Christine Leonard, M.S., LPC-A, LAC-A, NCACII, AADC, SAP, CS-IP, provide professional services to me (and/or my child as designated below) as a client, and unless otherwise discussed, I agree to pay this therapist's fee for these services as listed below:

SAP/DOT Related Services

SAP Evaluation (first appointment)	$300
(Includes initial appointment, and initial letter sent to employer)	
SAP Finalization Appointment (last appointment)	$100
(Includes follow-up appointment, final letter and drug testing plan sent to employer)	
SAP Non-Compliance Re-Evaluation	$200
(Required if education/treatment is not completed within designated timeframe)	

Counseling Service Fees

Diagnostic Evaluation	$175
Individual Counseling Sessions (50 minutes)	$60
Couples/Family Counseling Session (50 minutes)	$75

General Fees

Travel costs	$25 per hour
Report writing/Collateral Communications	$100 per hour
Records/document review	$75 per hour
Court appearances/depositions	$150 per hour
Copying costs	50 cents per page
Cancellation in less than 24 hours or No Show Fee	$40

SAP Training available to Employers and Employees & Motivation Interviewing Training Available

If at any time, I am dissatisfied with this therapy I will fully discuss my views, reasons, and plans with the therapist. If the client is a minor, I understand that while I have a right to general information on issues and progress, some information shared in this professional relationship may be held in confidence by the therapist and the minor child.

I agree that this financial relationship will continue in effect with the above-named professional as long as this therapist provides services or until I inform her that I wish to end it. I agree to pay for services rendered to this patient up until the time I terminate the relationship.

Signature: _____

Printed Name: _____

Relationship to the patient: o Self o Other: _____

Date: _____