Payment Agreement Form
For Couples Counseling

We, _____ and _____ agree to meet with Paul Iarussi, LMFT, for counseling and understand that the full fee for sessions is: $100 for individual or $150 for couples counseling. Our sessions will last 60 minutes for individual or 90 minutes for couples counseling. We are **aware that any cancellations of appointments must be made more than 48 hours before my appointment, unless it is an emergency and if we do not cancel or not show up,** I, we am/are **will be charged for the full fee of that appointment.** We agree to be financially responsible for the cost of treatment and I am aware that if we have not paid for services received or worked out a payment arrangement with Paul Iarussi, LMFT, treatment may be discontinued.

Please choose one of the following options by initialing:

_____ We are paying full fee for counseling and am aware that we must provide a credit card on file (using the credit card form below) or bring cash, or check to each appointment with Paul Iarussi, LMFT, unless other arrangements have been made.

_____We are electing to have our treatment paid in full or part by our insurance carrier or another third party, we will authorize this in writing and allow Paul Iarussi, LMFT, to release to an authorized agent of my insurance or a third-party payer information about the type(s), cost(s), date(s) of any service of treatment we receive. We are financially responsible for any portion of the fees not covered or reimbursed by my health insurance carrier. Further, we understand that we are responsible for preauthorizing sessions before beginning treatment and if we do not receive preauthorization, we are financially responsible for those sessions not covered by our insurance.

_____ We are not able to pay full fee for therapy and we have discussed a sliding scale fee with Paul Iarussi, LMFT and we have agreed upon _____per session as our fee.

We have been informed and agree to hold Paul Iarussi, LMFT, harmless from any losses, damages, liabilities, costs and expenses (including and without limitation of attorney's fees) arising from the release of such information to my insurance carrier, or to a third-party payer or to any other agent as designated by me.

We are aware that the practice of psychotherapy is not an exact science and so predictions of the effect are not precise or guaranteed. We acknowledge that no guarantees have been made to us regarding the results of treatment provided by Paul Iarussi, LMFT.

We understand that regular attendance will produce the maximum benefit, but that we are free to discontinue treatment at any time. If we decide to do so, we will notify Paul Iarussi, LMFT, at least two weeks in advance so that effective planning for termination and or continued treatment elsewhere can be implemented. We are aware that we will still be responsible for payment for the services that we received.

We understand that Paul Iarussi, LMFT is not providing an emergency service and we have been informed of whom and where we should call upon in an emergency or during weekend, vacations, and evening hours.

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We understand that all conversations with Paul Iarussi, LMFT are confidential. We further understand that Paul Iarussi, LMFT, by law, must report actual or suspected child or elder abuse/neglect to the appropriate authorities. In addition, Paul Iarussi, LMFT, has a legal responsibility to protect anyone if I may threaten harmful or dangerous actions (including those actions to myself) and may break confidentiality of our communication if such a situation arises.

Name (please print): _____

Signature: _____ Date: _____

Name (please print): _____

Signature: _____ Date: _____

Witness/Date: _____ Date: _____

Paul J. Iarussi MA, LMFT
RelationalCounselingServices.com
RelationalCounseling@gmail.com
512.693.7254

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Credit Card Form

Please read and completely fill out the form below. Once we have received your completed Payment Agreement, you may contact us to schedule future appointments. Your card information is confidential.

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 session fee unless you cancelled your appointment at least 48 hours in advance, business days – Monday through Friday; **for cancellations with less than 48 hours' notice, the full session fee will be charged. For missed appointments with no notice given, the full session fee will be charged.**

Your signature indicates that you understand that you, not an insurance company or other 3rd party payer, will be paying for your sessions, and 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 completed (if you wish to pay for the session with the credit card). Payments are expected at the time of service or in advance of service. Your signature indicates that if you don't pay by another form of payment at the time of service, your credit card will be charged for the appointment.

Your signature indicates that you may be charged for other services such as, extended phone calls, consultation on your behalf, and other services rendered on your behalf. These charges will be discussed with you ahead of the services provided.

Current Fees for Services:

Individual Counseling – 60 minutes	$100.
Individual Counseling – 90 minutes	$150.
Marriage Counseling/Family – 90 minutes	$150.
Marriage Counseling/Family – 120 minutes	$225.

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

Client 1's Name: (print) _____ Client 2's Name: _____

Client 1's Signature: _____ Client's 2's Signature: _____

Date: _____ Date: _____

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

Circle: VISA / MASTERCARD / AMEX / DISCOVER

Card Number: _____ Card Expiration Date: _____

Verification Number: _____ Billing Zip Code: _____

Billing Address: _____ City: _____

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