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Sliding Scale Payment Agreement

Please read completely. Sliding Scale payments are reduced fees from the normal counseling rates. *These agreements are limited and only reserved for those clients with financial need.* You must **discuss** this arrangement and be **approved** for reduced rates by your counselor. Once we have received the completed Sliding Payment Agreement, you may contact us to schedule future appointments. Your card information is confidential.

By completing and signing this Sliding Scale 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.

Sliding Scale Fees for Services: ***(Please complete with your counselor)***		**Your initials**	**Counselor's initials**
Individual Counseling – 60 minutes	$_____	_____	_____
Individual Counseling – 90 minutes	$_____	_____	_____
Marriage Counseling/Family – 90 minutes	$_____	_____	_____
Marriage Counseling/Family – 120 minutes	$_____	_____	_____

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

Client Name: (Please print) _____

Client Signature: _____ Counselor's Signature: _____

Date: _____ Client Phone: _____

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: _____