Payment Contract for Services

Name(s):

Address:

City State: Zip:

Bill to (Person responsible for payment of account):

Address:

City State: Zip:

Federal Truth in Lending Disclosure Statement for Professional Services

Fees for Professional Services

I (we) agree to pay Julie Cohen, LMFT, hereafter referred to as the psychotherapist, a rate of

$_____per clinical unit (defined as 45–50 minutes for assessment, testing, and individual, family, and relationship counseling).

A fee of $_____is charged for group counseling.

A fee of $_____is charged for missed appointments or cancellations with less than 24-hours' notice. This fee is usually not covered through insurance.

A fee of $_____is charged for writing a report.

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of this Disclosure Statement for Professional Services.

Person(s) responsible for account:_____Date:_____

Person(s) receiving services:_____Date:_____

Person(s) or guardian(s):_____Date:_____

Therapist:_____Date:_____