Larry Fernandez, LCSW #29009

Payment Contract for Therapy Services

Name(s): _____

Address: _____

City _____ State: _____ Zip _____

Bill to (Person responsible for payment of account): _____

Address: _____

City _____ State: _____ Zip: _____

Fees for Professional Services

I (we) agree to pay **Larry Fernandez, LCSW** a rate of:

___ ***$160 for individual therapy***

___ ***$200 for couples/relationship therapy***

___ ***$160 for family therapy***

___ ***Temporary Sliding Fee Scale in the amount of _____ per session.***

per clinical session (45–50-minute individual session, relationship counseling).

A fee of $ 100.00 is charged for missed appointments or cancellations with less than 24 hours' notice. This fee is usually not covered through insurance.

A fee of $ n/a is charged for writing a report.

Payments or co-payments will be billed directly to IVY Pay, Zelle or other agreed upon method and will be charged from account on file.

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 therapy services _____ Date _____

Therapist (Larry Fernandez) _____ Date _____