

2211 Corinth Avenue,, Suite 307, Los Angeles, California 90064

<b>Payment Contract for Services</b>
--------------------------------------

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 Part One Fees for Professional Services**

I (we) agree to pay Michelle Dean, MA, LMFT, hereafter referred to as the clinic, 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 \$800 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 the Federal Truth in Lending Disclosure Statement for Professional Services.

Person(s) responsible for account: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Person(s) receiving services: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Person(s) or guardian(s): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Therapist: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_