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Associate Marriage Family Therapist, AMFT # 79147
Supervised By: Brandi Garner, M.S.
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FEE AGREEMENT

Payments: Your fee for each 50-minute session will be _____, payable via cash, check or credit card (Visa or MasterCard). You are expected to pay your session fee at the start of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, releases of information, reading records, longer sessions, travel time, etc. will be charged at the same rate unless otherwise indicated and agreed upon. Credit card information will be kept private other than by electronic means for billing.

Cancellation Policy: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required to re-schedule or cancel an appointment. Clients are requested to provide a credit card number that can be used for billing in the event of a late cancellation or no show. The full session fee will be charged to the credit card number provided in the section below for appointments missed without notice or canceled with less than 24 hours notice, unless we are able to find a mutually agreeable time to reschedule the appointment within the same week.

Credit Card Authorization: Per the terms of this Financial Agreement document, in the event of a late cancellation (less than 24 hours notice) or missed session, you will be charged the full session fee. Unless otherwise agreed to, the fee will be charged to the credit card account provided below.

I,_____, (client or caregiver/payer name if services are being paid for by someone other than client) am authorizing Visualize Your Life Counseling Center to charge the session fee of _____ to the credit card indicated below in the event that I (or the client if services are being paid for by a caregiver or other adult) do not attend a scheduled therapy appointment without giving a minimum of 24 hours notice.

Card Type (circle one): **Visa** **MasterCard** **Card #**_____

Name as Printed on Card: _____Phone#_____

Billing zip code: _____Exp date: _____CVC (3 digit on back of card)_____

Authorized Cardholder Signature: _____Date: _____
I have read the above Fee Agreement document carefully, and I understand it and agree to comply with all its terms and conditions.

_____Date: _____
Client Signature

_____Date: _____
Caregiver Signature (if applicable)