Taylor-Made Well-Being

Cheryl Taylor, LMHC #MH25999

Financial Agreement for Services

Client's Name _____ Date of Birth _____

I understand that I am responsible for all payments for counseling services with Cheryl Taylor, M.Ed., Ed.D., Licensed Mental Health Counselor #MH25999 in Florida. I understand that I will be responsible for the full rate agreed upon service and that Cheryl does not bill insurance. I may choose to seek reimbursement through my insurance by submitting receipts, but whether or not I am eligible for reimbursement does not negate this financial agreement.

If I need to cancel an appointment, I understand that if I do not give at least 24 hours notice via phone call or text message to 610-763-7656, I will be automatically charged by my debit/credit card on file at the rate of $35.

By signing here, I understand and agree to the information in this contract and I authorize Cheryl Taylor to keep my credit card number on account for automatic debit in case of a missed appointment without 24 hours notice. This agreement shall stay in effect until I have terminated treatment or requested the end to this agreement in writing.

_____

Name of Person Responsible for Payment

_____ _____

Signature Date