New View Recovery, LLC

Catherine Mobley, LMHC, MCAP, QSFL, EMDR Trained

♦ Telephone: 689-291-4991 ♦ Email: cat@newviewrecovery.org ♦ www.newviewrecovery.org

Agreement to Pay for Professional Services

I request that the therapist, Catherine Mobley, LMHC, MCAP, QSFL, provide professional counseling services to me _____, and I agree to pay this therapist's fee of **$ 180.00 per hour** for these services. I understand that therapy sessions are to be paid in full before the beginning of each session. I have been given the option to submit income documentation (last tax return, W-2, or last 3 pay stubs) to use sliding scale rates.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or on the telephone that I wish to stop. If I do decide to end therapy, I agree to meet with this therapist at least **one more time** before stopping therapy, to help ensure appropriate closure of the treatment episode. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I understand that I am responsible for the charges for services provided by this therapist to me (or this client).
I understand that regular attendance to therapy is vitally important to ensure progress with the concerns and issues that I have presented. **I understand that if I need to cancel an appointment, I must call my therapist at 689-291-4991 at least 24 hours prior to the time of my appointment**. If I do not cancel or show up for an appointment, then I will be charged 100% the cost of my missed appointment fee, which is to be paid prior to my next session.
If a check is returned, then I must pay the therapist $25.00 to cover the cost of the returned check.
I also understand that if I have any mental health emergencies, I must call 911 or 988 as soon as possible!

I have also read this therapist's Informed Consent form and agree to act according to everything stated there, as shown by my signature below.

- ☐ I am electing to use my active in-network insurance benefits and understand it is my responsibility to ensure continued coverage. If there is a lapse in coverage, I am responsible for all fees of service. I also will be charged any co-pays on the date of service.

_____ _____

Signature of client **Printed Name** **Date**

_____ _____

Signature of financially responsible party **Printed Name** **Date**

I, the therapist, have discussed the above items with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Therapist: Catherine Mobley, LMHC, MCAP, QSFL **Date**