Salus
COUNSELING, LLC

AGREEMENT TO PAY FOR COUNSELING SERVICES

saluscounseling.com
SalusCounseling@ymail.com

I request that _____ (Counselor)

provide professional service to, myself _____ (Name of Client)

and/or to, _____ (Name of child, foster child, or legal dependent).

who is my _____ (child, foster child, or legal dependent).

- I agree to pay the counselors stated fees as listed in Informed Consent document and posted in the Treasure Wellness Lobby.
- I agree that this financial relationship with this counselor will continue as long as the counselor provides services or until I inform him/her, in person or by certified mail that I wish to end this professional relationship.
- I agree to meet with my counselor at least once before stopping therapy.
- I agree to pay for service provided to me or stated client up until the time that I have fulfilled my financial responsibility.
- I agree that I am responsible for the charges of service provided by this counselor, although other persons or insurance companies may make payment on my or clients behalf.

_____ _____
Signature of client (or guardian for client) Date

I, the counselor, have discussed the issues above 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.

_____ _____
Signature of counselor Date

❑ Copy accepted by client
❑ Copy kept by counselor

Payment information (Acceptable payment methods: cash, check, credit card, debit card.)

Please make checks payable to: ***Salus Counseling***

***For credit and debit cards*:**

Name as it appears on card_____Amount of payment:_____ Credit or debit (circle one)

Card #_____Expiration date: _____

Zip code:_____ 3 Digit code on back:_____