Heal Together Counseling, LLC
194A Pleasant Street, Suite 206
Concord, NH 03301
Phone: 401-584-4325
Fax: 978-616-7325

Educational Advocacy Financial Agreement

Service Fees:

60 Minute Session (38 – 52 minutes)……..……$100.00

Meetings……..…..……$100.00/hr
- This includes travel time, meeting preparation, & participation.
- After the first hour, this is invoiced in 15-minute increments.

Documentation Review……..$60.00/hr
- This is billed in 15-minute increments.

Late/No Show Fees……..$100.00
- Any cancellation with less than 24-hour notice or not showing without communication will be subject to this fee.

Financial Policies

- I understand that all fees are to be paid, in full, at the time of the scheduled session/meeting, unless alternative arrangements have been made with the therapist.

- I understand and acknowledge that educational advocacy is not covered by insurance and therefore I agree to pay the full fee for any services rendered in accordance with this fee agreement.

- I understand ALL cancellations require a minimum of 24 hours of notice prior to the scheduled appointment. Late cancellations (after the 24-hour period) are subject to the above listed fee and is the responsibility of the client.

- I understand that "No Show" sessions are subject to the above listed fee and is the responsibility of the client.

- I understand that an active credit card is required to be kept on file to pay for services rendered, fees, and balances.

- I authorize that my credit card can be processed for all charges related to services rendered, no show/late cancellation fees, late payment fees and other services provided in accordance with this fee agreement.

- Should I default in part or all of my financial responsibilities to pay, I understand that my name, address, telephone number, dates of service and balance owed will be disclosed to a collection agency. I authorize the release of this information for the purpose of payment collection.

Financial Responsibility Agreement & Policies

By signing below, I acknowledge that I have read and understand the fees associated with the above listed services and agree to the terms as outlined.

_____	_____
Client Name	Date
_____	_____
Parent/Guardian Signature	Relationship to Client
_____	_____
Provider Signature	Date

Heal Together Counseling, LLC
Rebecca Searles, MSW, LICSW
194A Pleasant Street, Suite 206
Concord, NH 03301
401-584-4325

Credit Card Authorization

I authorize Heal Together Counseling, LLC to charge my credit card for all services as outlined above. In addition, I authorize Heal Together Counseling, LLC to charge my credit card in the event of a late cancellation/missed appointment that did not comply with the 24-hour cancellation policy. I guarantee payment for all services rendered.

Should I choose to update the credit card that is on file, this authorization covers the use of all credit cards provided.

Name as it appears on the card: _____

Type of card: VISA Master Card Discover Other:_____

Card Number: _____

Expiration Date: _____ Security Code: _____

Address associated with the card:

Address: _____

City: _____ State: _____ Zip Code:_____

Phone: _____

Signature of Cardholder: _____

Relationship to client: _____

Date: _____