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

Parent Coaching Financial Agreement

Service Fees:

45 Minute (38 – 52 minutes)……………………………..…..……………………$75.00

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

Meetings……………………………………………………………………..…………$100/hr

- This includes travel time, meeting preparation, & participation.
- After the first hour, this is invoiced 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 appointment, unless alternative arrangements have been made with the therapist in advance.
- I understand and acknowledge that parent coaching 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 a $100.00 fee.
- I understand that “No Show” sessions are subject to a $100.00 fee and are 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.

- I understand that should I choose to dispute a charge against my credit card that was billed in accordance with the agreement above that Heal Together Counseling may terminate my services. Additionally, I am responsible for this charge and any fees incurred by Heal Together Counseling.

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

____________________________________ Client Signature	________________________________ Date
____________________________________ 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: ________________________________