Arcadia Counseling Center (ACC)

FEE AGREEMENT

for Services with

Crystal Contreras MC, LPC

All payment for psychotherapy is due on the same day of service. This provider accepts cash, personal checks and credit/debit cards. Individuals that do not attend therapy with the financially responsible party must bring payment with them or have the responsible party leave a credit card on file. Outstanding balances will not be carried forward unless the client has made a previous arrangement with their therapist.

OUT-OF-POCKET PAYMENT

The initial intake session will be charged at the rate of $145.00. Each 50-minute session thereafter will be charged at the rate of $130.00. Rates to review documentation or to prepare written reports will be charged at $60.00 per half hour. Time spent on the telephone and e-mail outside of scheduled appointments may also be billed at a rate equal to an in-office session. Initial _____

All clients are required to leave a credit card on file to address missed session/late cancellation fees and/or to pay their session fee if that is desired. Clients may request receipts via the form of a "Superbill" for reimbursement or personal purposes at any time.

I, _____, hereby authorize Arcadia Counseling Center, to charge my credit card as payment for my individual, family and/or group sessions on the same day the service is rendered for the amount or balance due and/or for missed/late cancel fees. If I do not wish to pay my session fee with my card kept on file, I understand a card will still be kept on file to be used for any missed/late cancel session fees incurred per the policy outlined in the ACC cancellation policy.

Type of Card: Visa: _____ MasterCard: _____ Amex: _____ Discover: _____

Credit Card Number: _____

Expiration Month & Year: _____

CVV (three digits on back of card)_____

Name of Cardholder: _____

Credit Card Billing Address: _____ (if different than one provided)

Authorized Signature of Cardholder_____

I acknowledge the payment policy described above, and assume full responsibility for all charges. I agree to honor and abide by the terms of payment.

Client Signature: _____ Date_____

Arcadia Counseling Center Cancellation Policy

If you fail to cancel a scheduled appointment within 24 hours of your scheduled session, we cannot use this time for another client. Therefore, you will be billed for the entire cost of your missed appointment. With the client's signature, it is understood by the client that a full session fee of $130.00 (not just the co-pay if you are utilizing insurance) is automatically charged for missed appointments/no shows and cancellations with less than a 24-hour notice.

Thank you for your consideration regarding this important matter.

Client/Guardian Signature: _____ Date: _____

Staff Witness: _____ Date: _____