ACCOUNT INFORMATION:

Responsible party:_____ Relationship to client:_____

Occupation: _____

Home Address: _____ Phone: ( )_____

Employer and Address:_____

Employer Phone: ( ) _____

E-Mail: _____

OFFICE BILLING POLICY:

1. I understand that I am responsible for the full amount of my bill for services provided.
2. Clients must pay their account IN FULL at the time of service unless a payment plan is set up with our office manager.
3. I understand that all payment plan payments are due by the 10th of each month.
4. Our office accepts, Visa, Mastercard, Discover, American Express, cash, and personal checks.

FINANCIAL AGGREEMENT

I have agreed to pay privately for my therapy.

The agreed upon charge is $_____ per session. Paperwork or other requests will be a separate cost if not done during the allotted time. Additionally, I acknowledge that my insurance will not reimburse me for my decision to see Successful Therapy privately. Successful Therapy will not bill my insurance.

**If you are unable to keep an appointment, we must be notified at least 24 hours in advance. Failure to do so will result in a missed appointment charge of $25.00. After 2 missed appointments you will be required to pay in full prior to your next scheduled appointment.

**If a phone session is ever needed outside the regular scheduled sessions there will be a $20 charge for the first 30 min. and $15 for every 15 minutes following.

X_____

Please sign indicating that you have read and agree to the above office policies. Thank You