Agreement to Pay for Professional Services

Initial

_____ I agree to pay a fee of $_____ per 45/50 minute session. (Self pay clients)

_____ I agree to pay deductible, co-pay and co-insurance fees as dictated by my insurance provider

_____.

_____ I understand that I am responsible for the charges for services provided by Amber M. Prather, LPC, and that my insurance provider may make payments on my account. If any part of my fees is being paid by my insurance provider or other third party payer, I understand that this may result in limitations to my confidentiality.

_____ I understand that I will be charged full fee for missed appointments without 24 hour notice. I understand that my insurance will not cover missed sessions.

_____ _____

Signature of client Date

_____

Printed name of client

_____ _____

Signature of therapist Date