FINANCIAL AGREEMENT

Financial agreement & authorization to charge credit/debit card:

- I acknowledge that each individual session is $155, and each relational session (involving the client and any additional family members, or sessions involving family members only/without the client involved) is $175.
- I understand that any phone conversation over 5 minutes will be charged at a prorated fee based on $175/hour.
- I acknowledge that each 25-minute phone consultation is $87.50, and each 50-minute phone consultation is $175.
- I understand that Virginia McCarley, LMHC, LPC does not accept insurance.
- I understand that Virginia McCarley, LMHC, LPC can provide a superbill, which will require diagnosis, and which I can submit to my insurance for possible reimbursement.
- I understand that understanding my insurance company's out of network benefits is my responsibility.
- I acknowledge that full payment is due at the time of service.
- I understand that any appointments scheduled but not kept/missed, as well as any appointments cancelled or rescheduled within 24 hours of scheduled time, will be charged a fee of $100/hour.
- I authorize Virginia McCarley, LMHC, LPC to charge my card, which will be kept on file using Square, for office charges.
- I acknowledge that a credit/debit card must be saved on file prior to any services being rendered.
- I understand that if my credit/debit card does not accept the charge, I will immediately make the payment to the practice.
- I understand that I may cancel this authorization at any time, but by doing so, I acknowledge that the balance owing will be due and paid in full.
- I acknowledge that credit/debit card transactions could be linked to Protected Health Information.
- I acknowledge that I am the financially responsible party, and that if I am paying for services for an adult client (over 18 years old), that a Release of Information, signed by the adult client, is required prior to any services rendered.

Financially responsible party information (if other than client; or guardian, if client is a minor):

First Name/Middle initial/Last name _____

Relationship to client _____ Phone number _____ Email _____

Address _____ City _____ State _____ Zip _____

I, the financially responsible party, have reviewed this Financial Agreement information, I agree to pay the agreed-upon fees, and I voluntarily agree to participate in psychotherapy services.

_____
Print name

_____ _____
Signature of Card Holder Date