

Elizabeth Lawton, LMHC

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(904) 452-4612

FINANCIAL AGREEMENT

STANDARD SERVICE FEES: The rates listed below are based on a 45-50-minute clinical hour.

Individual Session: \$100

Couple or Family Session: \$125

If a report, letter or consultation with an outside party is requested, I understand I will be billed for any time required to prepare documentation, or to conduct an in-person or phone consultation. The standard service fee listed above will apply.

FORMS OF PAYMENT AND PAYMENT POLICIES: The following forms of payment are accepted: cash or check. Clients will be responsible for payment at the time services are rendered.

Checks returned for insufficient funds will be charged \$25 in addition to the amount of the check. An invoice may be sent to your home for any outstanding balance.

CANCELLATION POLICY: If you need to cancel an appointment, 24-hour advanced notification is required. This allows your session time to be offered to another client. If you do not give sufficient notice or no notice is given at all, you will be charged a \$50 fee. This no-show or late cancellation fee cannot be billed to your third-party payer. You will be personally responsible for this fee. Emergency circumstances leading to late cancellations or missed appointments will be considered.

FEE AGREEMENT

I agree to remit at the beginning of each session a fee of \$ _____ per 45-50-minute clinical hour.

By signing below, I am indicating that I have read and understand the Financial Agreement and Fee Agreement and agree to comply with them.

Client's name (print) _____

Signature _____ Date _____

Client's name (print) _____

Signature _____ Date _____

Name of legally responsible parent or guardian (where required)

Signature _____ Date _____

Psychotherapist's name _____

Signature _____ Date _____