

## **Financial Agreement Form**

Client Name \_\_\_\_\_  
(Last Name, First Name Initial)

Initial Evaluation \$ \_\_\_\_\_ (50-60 minute session)  
Individual Therapy \$ \_\_\_\_\_ (50 minute session)  
Couples Therapy \$ \_\_\_\_\_ (50 minute session)  
Family Therapy \$ \_\_\_\_\_ (50 minute session)

Please initial the following statements and sign below.

\_\_\_\_\_ I agree to pay for each service(s) listed above, in full, at the time that the service is rendered. Fees may be adjusted by therapist. I understand this will be discussed with me first.

\_\_\_\_\_ I have read and understand the Billing Policy as stated in the "Client Agreement" form. In addition, I understand that I will be limited to pay by cash, money order, or credit card if I have a returned check.

\_\_\_\_\_ I have read and understand the Cancellation Policy as stated in the "Client Agreement" form.

\_\_\_\_\_ I understand that Healing Psychotherapy Practices of Georgia, LLC requests to keep a credit card, cash, or check on file in order to obtain any missed appointment fees or unpaid outstanding balances (either from client or insurance company)

\_\_\_\_\_ I am using my insurance for therapy sessions. I authorize Healing Psychotherapy Practices of Georgia, LLC to bill my insurance for services received. I also authorize my insurance carrier to direct payments to Healing Psychotherapy Practices of Georgia, LLC for services rendered.

**IF CLIENT IS 18 and OLDER and SOMEONE ELSE IS PAYING FOR SERVICES:  
IF CLIENT IS a MINOR and SOMEONE OTHER THAN LEGAL GUARDIAN IS PAYING FOR SERVICES:**

**By signing below, I acknowledge that I have read the cancellation and billing policies. I understand and agree to take responsibility for the financial obligation of the client indicated on this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I understand that I must cancel my financial obligation in writing.**

\_\_\_\_\_  
**Credit Card Holder Today's Date**

**Healing Psychotherapy Practices of Georgia, LLC**  
**1301 Shiloh Rd., suite 710 Kennesaw, GA 30144 Tel: 770) 792-0079**

**Credit Card Authorization**

This form will be securely stored in your clinical file and may be updated upon request at any time.

In addition to providing a credit card, to comply with the Financial Agreement, I authorize Healing Psychotherapy Practices of Georgia, LLC to charge my credit card for professional services as follows (initial by all that apply):

\_\_\_\_\_ For ALL visits during my time receiving therapeutic services with Healing Psychotherapy Practices of Georgia, LLC.

\_\_\_\_\_ For this visit only \_\_\_\_\_ (date), in the amount of \$ \_\_\_\_\_

Card Type (circle one):    Visa        MasterCard        Discover        AMEX

Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Name as Printed on Card: \_\_\_\_\_

**Verification/Security Code**

(For Visa, MasterCard, and Discover: 3 digit code on back of card by signature line. For AMEX: 4 digit code on front of the card): \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Card Holder Signature: \_\_\_\_\_ Date: \_\_\_\_\_