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

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)

***** If you are using insurance, you may have a different copay or deductible than the above amount. If your insurance refuses to pay, you will be responsible for the amount above.

Initial by the following statements. The last statement is for clients using insurance.

_____ 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. 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.

_____ 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)

_____ If 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
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Credit Card Authorization

THIS DOCUMENT WILL BE SHREDDED AFTER BEING UPLOADED TO OUR ELECTRONIC FILING RECORD. WE USE OfficeAlly's PracticeMate

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

Billing Address:_____
City:_____ State: _____ Zip:_____
Card Holder Signature:_____ Date:_____

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):_____