**PAYMENT AGREEMENT FORM**

**Cancellation Policy:** Clients can cancel or reschedule an appointment anytime, as long as they provide 24 hours’ notice. If you cancel an appointment with less than 24 hours’ notice, you will be charged for the appointment.

**MISSED APPOINTMENTS**: The Client is financially responsible for attendance to all scheduled appointments, unless cancelled with at least 24 hour notice. Minimum charges of $50 will be applied to my account for a late cancel and $65 for a no-show. This charge is NOT covered by insurance.

**ACCOUNT RESPONSIBILITY:** I am responsible for payment to Uplifting Counseling Services, LLC, for all services rendered, due at the time of the visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. If I default on any payment obligations as called for in this agreement, Uplifting Counseling Services, LLC, reserves the right to forward my information to collections, and an additional 30% may be assessed to my account to cover the costs of this action. There will be no obligation to provide continuing services to any client who names Uplifting Counseling Services, LLC. as a creditor in any bankruptcy filing.

**LITIGATION LIMITATION:** Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on **Kadiatu Tarawalie, Owner** to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

### Payment: Payment is required one (1hr) prior to schedule start of services.

**Pay By**: **Cash, Money Order, MasterCard, PayPal, Visa American Express,** **Discover**

**Cost per Session:** $60 - $120

**Sliding Scale:** Yes

##### **Accepted Insurance Plans**: **Presently, I do not accept insurance in my practice due to the below concerns**:

##### **CARD NUMBER:**

**CARD HOLDER NAME:**

**EXP DATE:**

**CVV CODE:**

I hereby give consent to charge my credit card below for any outstanding balance such as payments, fees or other amounts my carrier determines as payable by me:

**CARD HOLDER SIGNATURE: DATE:**