

When you need a hand...

Schwarz and Associates

A Christian Marriage and Family Counseling Practice

Office 562-467-6978

www.ChristianTherapyHelps.com

Fax 562-467-6977

Agreement to Pay for Professional Services

I request that _____, Marriage & Family Therapist provide professional services to me and/or to _____, who is my _____ and I agree to pay this therapist's fee of \$ _____ per session for these services.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or my church may make payments on my (or this client's) account.

I understand that I am expected to pay for services provided by my therapist at the time of service and that I may pay for services by check, cash, or credit card. Schwarz and Associates accepts the following credit cards: Visa, MasterCard and Discover. If paying by check I will make my check payable to *Schwarz and Associates*.

Signature of client (or person acting for client)

Date

Printed name of Client

I, _____, title _____, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist with title

Date

Copy accepted by client Copy kept by therapist

FORM 29.