PAYMENT AGREEMENT

(Please initial each item and sign below)

_______ Life Changes Counseling, LLC will bill your primary insurance company as a courtesy to you, but you (the client or responsible party) are ultimately responsible for paying in full for services received. If the insurance company fails to reimburse me for any reason, you will be responsible for payment.

_______ Payment (including copayment or deductible) is due at the time of your appointment. For your convenience, I accept cash, check, IVYPAY for credit cards and HSA along with Paypal.

_______ **If you need to cancel or reschedule an appointment, please provide as much notice as possible** so that I can offer the appointment to another client in need.

_______ All appointments require a **minimum** of **24 hour** notice. **$75 will be charged** for **cancelling (for any reason)** with **less than** the **full 24 hours. Attempts to reschedule or telehealth will be made to avoid fee. A no show is the same fee.**

_______ It is your responsibility to inform me of any insurance changes to ensure that I always have the most up-to-date information for you.

_______ A $35 fee will be charged for a returned check.

I agree with and commit to this payment agreement.

Client Name (please print): ____

Signature of Client: ______________________________ Date: ______________