Therapy Agreement

It is important that you understand your rights and obligations relating to your counseling experience. Carefully reading the information below will help you avoid any subsequent surprises. Please feel free to discuss any questions you have concerning this information with your counselor.

Your counseling sessions will be 45 to 50 minutes for a full hour session
The estimated term of therapy will be ______________sessions.
The feel for the therapeutic hour will be *$150.00.* This fee will be paid at the time the service is rendered. I do not accept insurance and so it will be the client's responsibility to bill their own insurance provider.

Payment is required at the time the services are rendered. Insurance reimbursement is solely the responsibility of the client. Your therapist will provide you with codes that may help you with this process. Heather Pearman MFT cannot and will not take responsibility for your relationship with your insurance carrier and their reimbursements to you.

Appointments must be canceled 24 hours in advance. Otherwise, a full session charge will be made directly to the client. The therapist can receive text messages for canceled appointments.

On occasion your counselor may deem it necessary to a particular testing instrument to expedite and enhance the quality of treatment. Charges or fees for this will be discussed in advance of utilization.

Telephone conversations and text messages and emails that exceed more than 5 minutes to attend to will be billed at 15 minute increments. Multiple emails sent in the same 24 hour period will be compiled, treated and billed as one single email.

About your financial responsibilities

I, the undersigned, hereby understand that payment of each session is due at the close of each session unless other arrangements are agreed upon in writing. For one time occurrences. In the event that credit arrangements have not been agreed upon in writing and the charges have not been paid within 30 days of the due date, I agree that the charges will be subjected to a late charge of 1.5% per month on the unpaid balance. The charge for a returned check is 30.00 in addition to the fee owed.

I, the undersigned, hereby agree that in the event of default the payment of any amount due, my name and other relevant information may be released by Heather Pearman MFT in order to recover payment for overdue balances.

I, the undersigned, have read and fully understand the responsibility of this agreement. I have received a copy of this agreement and herein agree to abide by all the conditions set forth.

Print Client Name Date

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Client Signature

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Therapist Signature