Children First Counseling, LLC
Renee L Armstead, MA, LPCC, RPT
Licensed Professional Clinical Counselor, Registered Play Therapist
1115 Bethel Rd
Columbus, OH 43220
Ph. 614.634.3513

Agreement to Pay for Professional Services

I, the client (or person acting for the client), request that the therapist named below provide professional services to me or to _____ , who is my _____, and I agree to pay this therapist's fee of $ 150.00 per session for these services.

If I fail to provide 24 hour advance notice prior to canceling a scheduled appointment, I will be charged $150 and $150 for a no show.

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 agree that I am responsible for the charges for services provided by this therapist to me.

Initial

____ I do not have or wish to use health insurance benefits and understand I am solely responsible for payment of services and fees.

____ I do wish to use my health insurance benefits and do hereby give consent to Renee L. Armstead, MA, LPCC, RPT to release or exchange information related to case management, utilization review, and/or the processing of claims. I understand that fees for services will be identified on the “superbill” that I will receive, and that it is my responsibility to submit the “superbill” to my insurance company if I wish to be reimbursed. I also understand that submission of the “superbill” does not guarantee payment or reimbursement of fees.

I have also read this therapist's "Information for Clients" brochure and agree to act according to everything stated there, as shown by my signature below and on the brochure.

_____
Signature of client (or person acting for client)

_____
Printed name

_____
Date