

Dan Drake, MFT, LPCC, CSAT

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Fee Agreement

_____ I understand that the standard one-hour *couples or family therapy* session is "50" minutes.

_____ I understand that the hourly (50 minutes) rate is \$_____ per therapy session and that payment in full is due at the beginning of each session. Fees are appropriately increased periodically with at least 30-day notification and new agreement is agreed on and signed.

_____ I understand that if I choose to submit to my insurance for reimbursement, I will receive a monthly invoice for services rendered. I realize that it is my responsibility to understand my insurance policy concerning mental health services and that I must inquire about out-of-network services.

_____ I understand that there is a **24-hour cancellation** policy and that I will be billed if I do not show for my appointment and/or if I do not call within 24-hour notice.

_____ I understand that I may request additional time if I need it at the end of the session, and that I agree to pay for that time accordingly.

_____ I understand that in case of forgotten payment for sessions rendered, my credit card will be charged for service fee plus surcharge fees. This will appear on my credit card statement as ProfessionalCharges.com.

_____ I understand that if I use my credit or debit card, an abbreviated form of *ProfessionalCharges.com* (i.e., *ProfCharges.com*) will appear on my statement. If I contest the charge and a chargeback occurs, I understand that I will be responsible for the chargeback penalty and any other costs incurred.

_____ I understand that after three consecutive sessions of nonpayment, therapy may be suspended and/or terminated with referrals.

My initial at each statement above and my signature below confirms that I have read, understand, initialed, and agree to the above statements.

Client Signature

Date

Client Print Name