synchrOnicity COUNSELING Kristine Kirsch, M. Coun., LPC

Payment Contract for Services

Name(s): _____

Address: _____

City: _____State: _____Zip: _____ Phone:_____

Bill to:
Person responsible for payment of account:_____

Address: _____

City: _____State: _____Zip: _____ Phone:_____

Employer:_____ Phone:_____

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES

FEES FOR PROFESSIONAL SERVICES

I (we) agree to pay **Kristine Kirsch, M.Coun, LCP**, hereafter referred to as the provider, a rate of **$85.00** for individual counseling and **$95** for relationship or family counseling for a standard 50 minute session, and **$120** for individual and **$130** for relationship and family counseling for an 80 minute session.

Payment is expected at time of service

A fee of **$45.00** is charged for missed appointments or cancellations with less that 24 hours' notice.

A portion of Kristine Kirsch's appointments are reserved for individuals requiring payment arrangements or sliding scale fees based on individual financial circumstances.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____

Date: _____/_____/_____