



Arlene Winkle, LMSW

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

PART ONE FEES FOR PROFESSIONAL SERVICES

I (we) agree to pay **Arlene Winkle, LMSW**, 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 than 24 hours' notice.

Additional fees may be charged for services not covered by insurance, such as extra report writing time, and any other services not covered by insurance.

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

PART TWO ALL CLIENTS

Payments are due at the time of service.

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: ____/____/____

RELEASE OF INFORMATION AUTHORIZATION TO THIRD PARTY

I (we) authorize Arlene Winkle, LMSW to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above-listed third-party payer or insurance company for the purpose of receiving payment directly to Arlene Winkle, LMSW. Synchronicity Counseling.

I (we) understand that access to this information will be limited to determining insurance benefits and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____

Date: ____/____/____

Person(s) receiving services: _____

Date: ____/____/____

Person(s) or guardian(s): _____

Date: ____/____/____