



Marci Danielson, M.S., LAMFT

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 **Marci Danielson, LLC** , hereafter referred to as the provider, a rate of **\$85.00** for individual counseling and **\$100** for relationship or family counseling for a standard 50 minute session, and **\$120** for individual and **\$150** for relationship and family counseling for an 90 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.

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 Nichole Jordan's appointments are reserved for individuals requiring payment arrangements or sliding scale fees based on individual financial circumstances.

PART TWO ALL CLIENTS

Payments, co-payments, and deductible amounts 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: ____/____/____

