Emily Drury, MSW, LCSW# 75824

Payment Contract for Services

Name(s): _____

Address: _____

City _____ State: _____ Zip: _____

Bill to (Person responsible for payment of account): _____

Address: _____

City _____ State: _____ Zip: _____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services

I (we) agree to pay Emily Drury, MSW, LCSW, hereafter referred to as the clinic, a rate of :

$ 185 per clinical unit (defined as 45–50 minutes for assessment, testing, and individual, family, and relationship counseling).

A fee of $ 185 is charged for group counseling.

A fee of $ 185 is charged for missed appointments or cancellations with less that 24 hours' notice. This fee is usually not covered through insurance.

A fee of $ 740 is charged for writing a report.

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

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(s) responsible for account: _____ Date: _____/

_____/_____

Person(s) receiving services: _____ Date: _____/

_____/_____

Person(s) or guardian(s): _____Date: _____/

_____/_____

Therapist: _____Date: _____/

Emily Drury, MSW, LCSW# 75824

_____/_____