**HIGH LEVEL**
Counseling Center 407-668-6025

ACCOUNT INFORMATION:

Responsible party: _____ Relationship to client: _____

Occupation: _____

Home Address: _____ Phone: ( ) _____

Employer and Address: _____

Employer Phone: ( ) _____

E-Mail: _____

OFFICE BILLING POLICY:

1. I understand that I am responsible for the full amount of my bill for services provided.
2. Clients must pay their account IN FULL at the time of service unless a payment plan is set up with our office manager.
3. I understand that all payment plan payments are due no more than the 1st of each month.
4. Our office accepts, Visa, Mastercard, Discover, American Express, cash, and personal checks.

FINANCIAL AGGREEMENT

I have agreed to pay privately for my therapy.
The agreed upon charge is _____ **(package of 04 sessions** of one hour each).
Paperwork or other requests will be a separate cost if not done during the allotted time.
Additionally, I acknowledge that my insurance will not reimburse me for my decision to see HLCC privately. HLCC will not bill my insurance.

**If you are unable to keep an appointment, we must be notified at least 24 hours in advance. Failure to do so will result in a missed appointment charge of $25.00. After 2 missed appointments you will be required to pay in full prior to your next scheduled appointment.

**If a phone session is ever needed outside the regular scheduled sessions there will be a $20 charge for the first 30 min. and $15 for every 15 minutes following.

X _____

Please sign indicating that you have read and agree to the above office policies. Thank You