

Fee Agreement

* Individual 60 minute session - \_\_\_\_\_\_\_\_\_\_\_\_
* Family 60 minute session - \_\_\_\_\_\_\_\_\_\_\_\_
* Couples 60 minute session - \_\_\_\_\_\_\_\_\_\_\_
* Play Therapy 50 minute session - \_\_\_\_\_\_\_\_\_\_\_
* Group 60 minute session - \_\_\_\_\_\_\_\_\_\_
* Supervision 60 minute session - \_\_\_\_\_\_\_\_\_\_\_
* Consultation 30/60 minute session - \_\_\_\_\_\_\_\_\_\_\_

I understand my payment is due at the time of each session.

I understand that if a session is missed or cancelled with less than 24 hours’ notice, I will be billed for the full amount of that scheduled session.

Signature of person responsible for payment:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_