Dawn Wade, MA, ATR, CHT, LMFT

Licensed Marriage and Family Therapist
Certified Hypnotherapist Registered Art Therapist
3175 Sunset Blvd., Suite 104 Rocklin, CA 95677
CA License MFC #53765 National Registration ATR #13-048
916-905-4278 Dawn@heartmindandhealth.com

FEE AGREEMENT

Payments: Your fee for each 50-minute session will be $_____, payable via cash, check or credit card (Visa or MasterCard). You are expected to pay your session fee at the start of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, releases of information, reading records, longer sessions, travel time, etc. will be charged at the same rate unless otherwise indicated and agreed upon. Credit card information will be kept private other than by electronic means for billing.

Cancellation/Reschedule Policy: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required to reschedule or cancel an appointment. Clients are requested to provide a credit card number that can be used for billing in the event of a late cancellation/reschedule or no-show. The full session fee will be charged to the credit card number provided in the section below for appointments missed without notice or canceled/rescheduled with less than 24 hours notice, unless we are able to find a mutually agreeable time to reschedule the appointment within the same week.

Credit Card Authorization: Per the terms of this Financial Agreement document, in the event of a late cancellation/reschedule (less than 24 hours notice) or missed session, you will be charged the full session fee. Unless otherwise agreed to, the fee will be charged to the credit card account provided below.

I,_____, (Client or caregiver/payer name if services are being paid for by someone other than Client) am authorizing Dawn Wade to charge the session fee of $_____ to the credit card indicated below in the event that I (or the client if services are being paid for by a caregiver or other adult) do not attend a scheduled therapy appointment without giving a minimum of 24 hours notice. If I otherwise attempt to seek repayment or void a payment through the credit card company, the account balance will be penalized a 25% processing fee (of the payment amount) for each occurrence. I also agree that the office may securely store this original form on file.

CREDIT CARD STATEMENT WILL READ: "Dawn Wade, LMFT"

Card Type (circle one): **Visa MasterCard AMEX Card#**_____

Name as Printed on Card: _____ Billing Ph#_____

Exp date: _____ CVC (3 digit on back of card): _____ Billing zip code: _____

Authorized Cardholder Signature: _____ Date: _____
I have read the above Fee Agreement document carefully, and I understand it and agree to comply with all its terms and conditions.

_____ Date: _____
Client Signature

_____ Date: _____
Authorized Guardian/Caregiver Signature/Representative (if applicable)