



Financial Policy and Payment Contract for Services

Name(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Bill to: Person responsible for payment of account: _____

Address: _____ City: _____ State: _____ Zip: _____

Thank you for choosing the Family Counseling Center as your mental health care provider. We are committed to providing the best care possible. Please understand that payment of your bill is considered a part of your treatment. The following information explains our Financial Policies which we ask you to sign as an indication of your understanding.

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services

I (we) agree to pay **Family Counseling Center**, hereafter referred to as the clinic, a rate of \$ _____ per clinical unit (defined as 45–50 minutes for assessment, testing, and individual, family and relationship counseling).

A fee of \$ **20.00** per session is charged for group counseling.

An additional fee of \$ **30.00** is the standard charge for most tests/assessments. This fee does not include the additional expense of \$ **60.00** for report-writing.

A fee of \$ **30.00** is charged for missed appointments or cancellations with less than 24 hours' notice.

Part Two All Clients

Payments are due at the time of service. The center does not accept third party payment from insurance groups. However, for your convenience, you may request a statement of your account which is suitable for filing directly with your insurance carrier. The center reserves the right to impose a 1% per month (12% Annual Percentage Rate) interest charge on all accounts that are not paid within 60 days of the billing date.

Checks that are returned to us, unpaid, will automatically result in additional \$ **30.00** fee. We will contact you immediately requesting an alternate form of payment. If this matter can not be resolved within thirty days, we reserve the right to submit your account to collections, with any fees associated being the sole responsibility of the client.

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: ____/____/____

104 E. High Street, Manchester, TN (931)723-0380 * 1000 Collorado Blvd, Shelbyville, TN (931)680-8998, * 5542

Manchester Hwy, (Smartt) Morrison, TN * Winchester, TN * <http://victory4families.org>

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

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