



**Rachel Gracia Counseling, PLLC
Rachel Gracia, MA, LPC**

Financial Information and Agreement

1. The fee for counseling is as follows: Intake, 50 minutes, \$125

Session, 50 minutes, \$125

POLICIES AND PAYMENT:

APPOINTMENTS: your appointment time is reserved exclusively for you. **Appointments cancelled with less than 24 hours' notice will be charged a \$50 NO SHOW FEE.**

I authorize the therapist to charge my card for my late cancellations or therapy services, should it become necessary:

CARD NUMBER: _____ - - - - - _____ - - - - - _____ - - - - - _____

EXPIRES: _____ / _____ Security Code _____

NAME AS IT APPEARS ON CARD: _____

SIGNATURE: _____

Payment for services is due at the time of service and is the responsibility of the client. Due to a wide variety of insurance policies, I cannot guarantee that, if you choose to file for reimbursement, your insurance company will pay. You are ultimately responsible for payment. If you fall behind on payment, I have the right to discontinue services until payment for prior services is received. You agree to have an updated valid credit or debit card on file through active care. **Initial here:**

RETURNED CHECKS will be charged a \$25 fee.

I have read this page, received a copy, and agree to abide by the policies and procedures described.

DATE: _____ / _____ / _____

Client Signature: _____

Signature of Responsible Party (Financial Guarantor) if different: (a guarantor has the right to know if their payment is used for sessions or no shows/late cancellations):

Guarantor Signature: _____