

**COUPLES THERAPY
CONSENT & PAYMENT AGREEMENT
ELICIA SEAY, PH.D., LLC**

*****PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED*****

Fees & Payments: By signing below, you are confirming that you understand that Elicia Seay, Ph.D., LLC only accepts self-pay for couples therapy. You understand that you will be responsible for payment at the end of each session.

_____ (patient initials)

Patient Discharge / Collections Fees: In the event of failure to pay for services rendered, you understand that you may be discharged from the services until such time as your account is paid. Additionally, you understand that you may be referred to a collections agency for non-payment of fees due for services rendered. You understand that you will be responsible for a 30% collection fee, all agency and attorney fees and costs associated with the collection process (such as court costs), and that these fees and costs will be added to your account balance. You understand that you will be responsible for paying the entire amount of your balance due *in addition to* the collection agency fee. Further, you understand that your PHI will necessarily be revealed in these efforts to collect payment of monies owed.

_____ (patient initials)

Returned Check Fee: A \$35.00 fee will be assessed for each returned check.

_____ (patient initials)

Professional Fees: My hourly fee is \$200.00 for couple's therapy. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will pro-rate the hourly fee for periods of less than one hour. Such other services include report writing, telephone conversations lasting 15 minutes or longer, consulting with other professionals (with your agreement and permission), preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$250.00 per hour (with a minimum engagement of three (3) hours) for preparation for and attendance at any legal proceeding.

_____ (patient initials)

Meetings/Missed Appointments: Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of the cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. All missed appointments which were canceled fewer than 24 hours prior to the scheduled appointment time will be billed at \$100.00 fee. If you do not show up for your scheduled appointment, you will be responsible for the full cost of the session (\$200.00).

_____ (patient initials)

Your signature below indicates that you have read this entire agreement and agree to its terms.

Signature: _____ **Date:** ____ / ____ / ____