**Agreement to Pay for Professional Services**

I, the client (or guardian/legal representative), request that the therapist named below provide

professional services to me and my partner. I agree to pay this therapist's fee of $ 150 per 50   
minute session to Horizons of Hope (Shelly Kepler). This same fee will be applied per each hour of consultation, assessment, or other therapeutic activity unless otherwise negotiated in writing. Payments can be made by cash, check or credit card ($3 service fee for CC payment). Any checks returned to my office are subject to an additional fee of up to $35.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payments.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account. If my any part of my fees is being paid by an insurance company or other third party payer, I understand that this may result in limitations to my confidentiality.

If my therapist is subpoenaed or court ordered to testify or provide a report, I understand these services will be billed as ‘Forensic/Court-Related Services’ at a rate of $250 per hour. Fees will be inclusive of all time and travel, including preparation, depositions, and discussions with the parties and/or the attorneys. **An advance retainer will be required** before any court appearance or court service is performed and will be based on an estimate of the number of hours required. **Insurance cannot be billed for any court appearance or court service.**

I understand I am required to give a 24 hour notice if I am unable to keep a scheduled appointment. If I do not provide 24 hour notice, I will be responsible to pay the full session fee for the missed appointment prior to receiving any additional services. I understand that if I do not pay for services that the services provided may be terminated by the therapist.

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Signature of client (or person acting for client) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client (or person acting for client) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of therapist Date