

FAMILIES FIRST THERAPY, LLC
SELF PAY PAYMENT AGREEMENT

Client Name: _____

Responsible party (if different): _____

I _____, agree to pay \$_____ per session, **for psychotherapy services** received through Families First Therapy, LLC.

I also agree to, and understand, the following conditions:

- Sessions are defined as one hour in length. Extended fees may be incurred for longer sessions.
- The client, or responsible party, will be held responsible for all fees charged.
- Sliding scale fees are to be determined using the client's household income and the number of people in the household. All sliding scale arrangements must be made in advance of the session.
- Fees are due at the time of each session and will be accepted in the form of cash, check, credit card, or money order.
- Fees will only be refunded in the event that the service is not delivered.
- Non-payment of fees could result in the discontinuation of services to the client.
- Clients will be billed for any unpaid services via an invoice by mail. Any unpaid balances may be turned over to collections after 30 days.
- Insurance will NOT be billed for these services; consequently none of the fees for services will be applied to an insurance plan's annual deductible.

Signature of client or responsible party

Date

Signature of Stephen Ratcliff, MA, LPCC

Date

Cell (505) 504-5449
Fax (844) 840-7345
www.familiesfirsttherapy.org
steve@familiesfirsttherapy.org
steve@familiesfirsttherapy.org