Payment Agreement

Fees

Unless otherwise agreed to by you and your therapist, sessions are billed as follows:

$220 for an initial 90 minute appointment and $170 for ongoing 50-minute sessions. Except for brief phone contacts, you will be billed for phone therapy, emails or other professional services (including assessments and letters to outside professionals, extended coordination of care with other professionals) at the rate of $170 per hour. You will be informed of any services requiring additional payments before the services are rendered.

Confirmation of your Appointment and Cancellation Policy

You will receive a text message the morning before your scheduled appointment as a courtesy. This message asks that you confirm your attendance by responding to the text. We ask that you do us the courtesy of responding so that we can plan our day.

Late cancellations and no-shows impact us significantly. We understand that sometimes you may need to change your schedule and we kindly ask for more than 24 hours' notice as a courtesy to our clinicians and wait-listed clients.

If you change or cancel after the reminder text is sent out, you will be charged 100% of your appointment fee. The full fee for your session is also payable if you change or cancel on the day of the appointment or you fail to attend.

These fees will be deducted from your nominated credit card that is held on file. Your account must be up to date before further appointments will be made.

Please note that for consultations on Mondays we would require notice prior to 12 noon on the previous Friday except in the case of a genuine emergency.

Our office is available during normal business hours on 02 6176 1336 and our practice admin team are more than willing to help you organise your appointments. Voicemail can also be left after hours.

Payment

To allow for compliance with these policies, please provide a credit or debit card to be kept on file. Please complete the information below:

CARDHOLDER INFORMATION

Name: _____

Billing Street Address: _____

Street Address (cont.): _____

City: _____ State: _____ Postal Code: _____

Email: _____

Phone: _____

CREDIT CARD INFORMATION

Credit Card Type: ☐ MasterCard ☐ Visa Card Number: _____

Expiration Month: _____ Expiration Year: _____ CCV (on reverse of card): _____

Cardholder Signature: _____Date: _____

Any fees incurred by your therapist from credit card companies, collection agencies or banks due to non-sufficient funds, payment disputes, or non-payment of fees will be passed along to the client.

I agree that I am responsible for the charges for services provided by this therapist to me although other persons or insurance companies may make payments on my account if previously arranged with Footsteps Psychology.

By providing my signature below, I am authorising this therapist and the administrative staff to keep a secure copy of my credit card on file for use to comply with the policies referenced above.

I understand that this form is valid through the expiration date on the card, unless I cancel the authorisation through a written notice to this organisation.

Printed name: _____

Signature: _____ Date: _____

Email to send receipt to: _____