

Laurie J. Hall, LCSW

Psychotherapist

5575 Lake Park Way, Suite 114

La Mesa, CA 91942

(619) 297-0025/ Fax (619) 463-8986

Payment Contract

Primary Client:			D.O.B		
				is your responsibility to be Insurance being used is	
My insurance pays _	% for my ment	al health benefit and I l	have a co-pa	nyment of	
I understand that my	fee has been set at \$_	per therapy se	ssion.		
I have read and agre	ed to the terms of this pa	ayment contract.			
				Initials	
	Cancellations	and Failed App	ointment	es	
p.m.) for cancelled a	appointments. I understa After two failed appoin	and that I will be billed	1\$	hours of 10:00 a.m. to 7:00 for therapy sessions missed ed full fee at \$ This	
				Initials	
LCSW to charge m	y credit card for failed	appointment fees. I u	understand r	. I authorize Laurie J. Hall, my credit card will only be in another form (i.e. cash or	
Clients Signature/Parent/Legal Guardian			Date		
Laurie J. Hall, LCSW		_	Date		
		FOR OFFICE USE ONI	LY		
Name on Credit Card:					
Billing Address for Card:					
Credit Card Number:					
Expiration Date:		CVV (3 digit code on back	V (3 digit code on back of card):		
Credit Card Type:	□ VICA □ Macto	rCard			