Laurie J. Hall, LCSW
Psychotherapist
1545 Hotel Circle South, Suite 250
San Diego, CA 92108
(619) 297-0025 / Fax (619) 996-2152

Payment Contract

Primary Client: _____ D.O.B._____

Payment is due at the time that services are rendered. Please note that it is your responsibility to be assured that payment will be covered either by yourself or a third party. Insurance being used is _____.

I understand that my fee has been set at $ _____ per therapy session. I have a co-payment of _____.

I have read and agreed to the terms of this payment contract.

Initials _____

Cancellations and Failed Appointments

I am aware that I am responsible for giving 1 business day notice (from the hours of 11:00 a.m. to 7:00 p.m.) for cancelled appointments. I understand that I will be billed $ _____ for therapy sessions missed without prior notice. All subsequent failed appointments will be billed full fee at $_____. This policy is enforced without exception.

After 2 failed or cancelled appointments, I realize that my appointment time may not be held for me, that our work together may need to end, and that I may be referred to another therapist.

Initials _____

By signing below, I understand the cancellation and failed appointment policy. I authorize Laurie J. Hall, LCSW to charge my credit card for failed appointment fees. I understand my credit card will only be used under these circumstances and/or when I have failed to provide payment in another form.

_____ _____
Clients Signature/Parent/Legal Guardian Date

_____ _____
Laurie J. Hall, LCSW Date

Please complete			
Name on Credit Card:			
Billing Address for Card:			
Credit Card Number:			
Expiration Date:		CVV (3 digit code on back of card):	
Credit Card Type:	❑ VISA ❑ MasterCard		