Counseling Services of Arizona
Heidi Quinlan LPC, LISAC
3048 E. Baseline Rd., Ste. 107
Mesa, AZ 85204

Today's Date:_____

Financial Information and Agreement

Authorization for Debit/Credit Card Charges

I _____ understand that Counseling Services of Arizona PLLC requires to have my credit card or debit card information on file in order to receive therapy services. Below is a list of services provided by Counseling Services of Arizona PLLC that may be charged to my card if the services are provided. If a different method of payment is preferred, payment will be taken care of at the time of services. If payment is not made at the time of service, the amount of the service will be charged to the credit or debit card.

Fee Schedule:

Initial Assessments/Intake Appointment (90 min.)	$100.00/session
Individual Therapy Session (Office Visit) (50 min.)	$85.00/session
Family/Couples/EMDR Session (Office Visit) (60-90 min.)	$95.00/session
Family Sessions (In-Home Visit) (60-90 min.)	$110.00/session
Telephonic Consultation (Billed in 15 min. increments)	$25.00/15 min.
Correspondence/Reports	$25.00/page
Face-to-Face Meetings/Staffings (Billed in 15 min. increments)	$25.00/15 min.
Attendance at Court (Billed per day)	$400/day
Returned Check Fee (per occurrence)	$35.00/occurrence
Copies/Faxes received over 15 pages	$0.25/page
Late Cancellations/Missed Appointments (*See note below)	$50.00/session

Name as it appears on the card: _____ Phone #: _____

Email Address: _____

Debit/Credit Card #: _____ Expiration Date: ____/____

CVV (CSC) # _____ (For MasterCard or Visa, it's the last three digits in the signature area on the back of your card. For American Express, it's the four digits on the front of the card.)

Billing Address: _____

Street Address Apt #

_____

City State Zip Code

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*Late Cancellations/Missed Appointments: Fees are applied at the stated hourly rate of $50.00.

Client/Parent Initial_____Other Parent/Spouse/Guardian_____

Courtesy or Second Party Payers: Please understand that the Client/Parent/Guardian is responsible for paying all fees. This office will allow a courtesy payer or a second party (i.e. adult parent paying for an adult child, church or other organization as payer, etc.) to pay for services. However, we will not discuss appointments or appointment schedules with courtesy payer because of confidentiality unless a Release of Information has been signed.

Client/Parent Initial_____Other Parent/Spouse/Guardian_____

Outstanding Balance: Any accounts with a balance outstanding longer than 30 days will accrue interest at the rate of no less than 10% per month. If necessary, this office will utilize the services of a collection agency where the client/parent/guardian is responsible for all fees associated with collection.

Client/Parent Initial_____Other Parent/Spouse/Guardian_____

By my signature, I acknowledge reading and agreeing to the above financial terms.

_____ _____

Signature Date

_____ _____

Signature Date