



## **Payment Agreement**

**Effective October 1, 2012**

**I understand that I am responsible to pay for services received each time that I attend a session at Full Circle Therapy.**

I further understand that cancelled appointments require at least 24 hours notice. In the case of a cancellation without 24 hour notice, a missed appointment or a late arrival, I may be charged for a full session. Insurance companies or public assistance funds will not pay for appointments that are cancelled or missed.

The agreed upon fee for clinical services is as follows:

**Individual: \$140.00**

**Family/Couples/Intake: \$160.00**

A finance charge of 1.5% will accrue on accounts 90 days past due. A \$30.00 service charge will be added for returned checks.

The clinic reserves the right to use collections or conciliation court on accounts 90 days past due.

I understand and agree to the above conditions:

**Client/Parent/Guardian Signature:**

---

**Date:** \_\_\_\_\_

Telephone: 952-892-8404  
Fax: 952-892-1722