



The Healing Path Counseling Services

Payment Agreement for

Psychotherapy Services with Irving Najman, MA, LMFT, CSAT

By signing below, I am agreeing to participate in individual psychotherapy with **The Healing Path Counseling Services, PLLC**. This authorization complies with HIPPA Privacy Rules. I have received a copy of the HIPPA Privacy Practices/Client's Rights and have had the opportunity to ask questions about related confidentiality practices.

Payment Agreement for Psychotherapy Services:

I agree to pay the following amount for psychotherapy services at the time the service is provided unless otherwise arranged:

\$ 125.00 per session for individual therapy. Session duration is 50 minutes unless arranged otherwise.

\$ 200.00 per session for individual therapy. Session duration is 90 minutes unless arranged otherwise.

\$ 150.00 per session for couples/family session. Session duration is 50 minutes unless arranged otherwise.

\$ 270.00 per session for couples/family session. Session duration is 90 minutes unless arranged otherwise.

\$ 125.00 per session for assessment session. Session duration is 50 minutes unless arranged otherwise.

\$ 125.00 for testing (SDI-4.0 and PTISI-R) and interpretation

\$ 75.00 for testing (SDI-4.0) and interpretation.

\$ 50.00 for testing (PTISI-R) and interpretation.

\$ _____ per session for group therapy. Session duration is _____ minutes unless arranged otherwise.

\$ 5.00 OFF DISCOUNT for CASH/CHECK payment

I have read the client's rights form and understand the fee schedule. In signing this form, I understand my rights as a client and responsibilities for payment. I also understand the above credit card will be charged if sessions are missed without 24 hours of notice and that it is my responsibility to update the credit card information, as applicable.

Print name: _____

Signed: _____ Date: _____

Clinician's signature: _____ Date: _____

I agree to pay the above rate for sessions that are missed/cancelled without 24 hours of notice. I also agree to keep the following credit card on file to pay for missed sessions that were not cancelled within the 24 hour window.

Credit Card Number: _____ **Expiration Date:** _____

CCV Code: _____ **Billing Zip Code:** _____ **Client initials:** _____