<u>Fee Agreement</u>

Client Name: ___________________________ Date: _____________

In order to continue offering therapeutic services to you and others at Lisa Haysmer, LMSW, LLC, it is important that you keep all of your scheduled appointments. Therefore, we ask that you agree to the following:

I understand that if I cannot attend or will be late to any scheduled appointments, it is my responsibility to notify Lisa Haysmer, LMSW, LLC at least 24 hours in advance. If I fail to provide 24 hours notice, I will be responsible for a **"No Show/Late Cancel" fee** of $40.

I understand that there is a $25 Non-Sufficient Funds bank fee for checks that do not clear.

I understand that through my insurance, I have an annual deductible of ________________ and a copay of _____________. In the absence of insurance, my fee for an intake assessment will be $100 (first session) and my fee for an individual /family session will be ____________.

By my signature, I acknowledge my responsibility for the above fees whenever applicable. I understand that I must pay these fees when due before services can continue.

_____________________________________ ____________________

Client/Guardian Signature Date

_____________________________________ ____________________

Therapist Signature Date