



GRACE & TRUTH CHRISTIAN COUNSELING

16707 Highway 45, Louisville, IL 62858

618-665-3050 (Counseling Office)

Payment Agreement Form/Cancellation Policy

Please read through our payment agreement and cancellation policy. Initial by each of the following and sign at the bottom:

1. I agree to pay the amount for counseling each session based on the sliding scale fee established at the first session. _____
2. I understand that there may be a \$15.00 charge for returned checks. _____
3. I understand that I may call my counselor if a non-emergency crisis arises; however, I will be charged for the phone calls based on the following: _____
 - Under 10 minutes – no charge
 - 11-30 minutes – ½ of the session fee
 - 31-50 minutes – full session fee
4. I understand that if a life-threatening emergency arises, I need to call 911 or go to the emergency room for a medical or psychological evaluation. _____
5. I understand that my scheduled appointment has been saved for me. If I need to cancel my appointment I will give **at least a 24-hour notice** before the scheduled appointment. I understand that if I do not give a **24-hour notice** that I will be charged the full fee for the missed session. The counselor will always consider emergencies when charging for a missed session or a late cancellation. _____
6. I understand that the counselor has the right to cancel a client after missing three sessions and that I will be able to begin again later after my bill has been paid in full. _____

I have read and understand the above information. By signing this form, I agree to the terms stated above.

Signature: _____

Date: _____