Victoria Easom, M.A., LPCI
Restore Counseling, LLC
27 Gamecock Ave., Suite 202
Charleston, SC 29407
843.608.0714

FINANCIAL AGREEMENT

I agree to pay Restore Counseling, LLC the rate of $_________ per session for all counseling services rendered & acknowledge that I have been informed of the financial policy.

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.
The only exception to this is a signed, attached payment plan developed prior to the date of service. My initials below indicate my understanding of and agreement to the following statements:

____________ The counseling session is 40-50 minutes in length & any time spent in excess of this may be billed as a separate session.

____________ A minimum of 24 hours notice is required for any appointment cancellation. My credit card on file will be charged a $30.00 fee for any missed appointment if the above notice is not given.

____________ Any services provided over the phone may be subject to the stated session rate listed above.

____________ Acceptable methods of payment include cash, certified check, or major credit card. No personal checks will be accepted.

____________ I am responsible for all charges incurred.

I hereby consent to treatment & affirm that I have read this financial agreement. Any questions regarding this financial agreement have been answered to my satisfaction & I agree to abide by these terms in full.

____ ___________________
Client Signature Date

____
Client Printed Name

____
Signature of Responsible Party (if different from client)

____ ___________________
Witness Date