ARCH PSYCHOTHERAPY & WELLNESS
225 S. MERAMEC AVE, SUITE 218
CLAYTON, MO 63105
WWW.ARCHPSYCHOTHERAPY.COM

Fee Agreement:
Justin Hampton, LCSW

Name(s):_____

Billing Address:_____

City:_____ State:_____ Zip:_____

Phone(s):_____

E-mail(s):_____

The following are the current rates for service. By signing this agreement, you agree to reimburse your clinician at Arch Psychotherapy & Wellness at these rates. If a new rate is negotiated, a new billing agreement must be signed. Current payment forms include cash, check, money order, and credit card (Visa, MC, or Discover).

Initial Consultation:	❑ $145.00	❑ Other: $_____
Individual or Couple Session:	❑ $125.00	❑ Other: $_____
Group:	❑ $50.00	❑ Other: $_____

Please initial each of the following to indicate agreement:

_____I agree to pay for all services provided, due at the time of service. I understand that failure to do so may result in my account being referred for collections.

_____I understand that a convenience fee of 3% will be assessed for credit card transactions.

_____I agree to pay a late cancellation fee of $75.00 for sessions not attended and not cancelled with 24 hours' notice.

_____ _____
Signature of client or payor Date

_____ _____
Signature of second client or payor (if applicable) Date

_____ _____
Representative of Arch Psychotherapy & Wellness Date