



ARCH PSYCHOTHERAPY & WELLNESS

225 S. MERAMEC AVE, SUITE 218

CLAYTON, MO 63105

WWW.ARCHPSYCHOTHERAPY.COM

Fee Agreement:
Jamie Fickert, PsyD

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: \$160.00 Other: \$ _____

Individual or Couple Session: \$140.00 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