Smiling Spirit Pathways
122 N. Salem St. Suite 201N,
Apex, NC 27502

Payment Contract for Services

Name(s): _____

Address: _____ City: _____ State: _____ Zip: _____

Bill To: (Person responsible for payment of account) _____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One **Fees for Professional Services**

I (we) agree to pay Smiling Spirit Pathways:

- A rate/fee of $_____ for the Initial Assessment
- A rate/fee of $_____ for Individual Therapy (adult/child/adolescent)
- A rate/fee of $_____ for Family Therapy
- A fee of $ _____ for cancellations with less than 25 hours' notice
- A fee of $_____ for missed appointments
- Group sessions/workshops will have varied fees and clients will receive separate agreements

Part Two **Clients with Insurance (Deductible and Co-payment agreement)**

Smiling Spirit Pathways is a fee-for-service provider. We do, however, have excellent partnerships with most insurance as an out-of-network provider. Payments are expected at time of service, at which time you will be presented with a receipt containing appropriate information to submit to your provider. Please contact your insurance provider for benefit information. The person responsible for payment of account shall make payment for services. The amounts charged for professional services are explained in Part One above.

Part Three **All Clients**

Payments are due at the time of service unless otherwise arranged with Smiling Spirit Pathways.
I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for the account: _____ Date: ____/____/_____

Person(s) responsible for the account: _____ Date: ____/____/_____

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Person(s) receiving services: _____ Date: ____/____/_____

Parent(s) or guardian(s): _____ Date: ____/____/_____