Faith E. Winters, LPC
Mental Health Counseling, Individual, Marriage & Family Therapy
Licensed Professional Counselor, Oregon # C1832
13831 NW Cornell Road, Suite # 104, Portland, Oregon 97229 503 267-3149

Agreement to Pay for Professional Services

I _____
request that Faith Winters provide professional counseling, talk therapy services.

☐ Psychotherapy/counseling services: ***$100 per 50 minute session, $120 for intake session. 10% unbilled discount when paid in full at each session.***
Preparation of reports, letters, and phone calls over 5 minutes will be pro-rated as a partial session.

☐ I agree that payment for services is due at the time of service and that I am fully responsible for payment, even if insurance is billed. I understand that there is no guarantee of insurance coverage/reimbursement for fees.

☐ In order to avoid full charges for missed appointments; I understand that I must call at least 24 hours in advance if I am unable to keep the scheduled appointment.
(Insurance is unlikely to cover the cost of any missed appointment fees)

☐ I understand that my therapist **will not** be available for 24 hour crisis intervention or emergencies and I have been informed where to call if I have an emergency. (911)

☐ I acknowledge that I have received a Professional Disclosure Statement and a Notice of Privacy Practices for Faith Winters, LPC. I will review both documents and know that I am encouraged to discuss any further questions with my therapist at any point in my treatment.

I have read and understand the above information. I consent to therapy in full agreement with the terms stated above and the understanding that my therapist and I will clarify goals and objectives at any time.

X _____ _____
Signature of client (or person acting for client) Date

_____
Relationship to client, if acting on behalf of client

I, Faith Winters, LPC, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____ ☐Copy accepted by client ☐Copy kept by therapist
Signature of Therapist Date