CHAGRIN COUNSELING ASSOCIATES

29525 Chagrin Blvd., Suite 313
Pepper Pike, Ohio 44122

20525 Center Ridge Rd., Suite 365
Rocky River, Ohio 44116

FEE AGREEMENT

I understand that I am responsible for the full amount of my bill for services provided.

I understand that payment is due on the day that services are rendered.

I am aware that there is a 24-hour cancellation policy and that I must cancel my appointment at least 24 hours in advance to avoid being charged.

I understand that if payment is not received by the date of service my session fee will be charged to the credit card on file.

I understand that it is my responsibility to investigate my out-of-network insurance benefits and to understand that company's policy for reimbursement of out-of-network providers.

The following credit card information will be kept confidential and will only be used in the event that payment is not made on the date of service, an appointment is cancelled with less than 24 hours notice (except in the case of an emergency), or the client authorizes the credit card to be used as the method of payment.

Name:_____ Date: _____
Type of Card: _____
Card #: _____
Expiration Date: _____
Home Address: _____
V-code (the 3 or 4 digit code found on the front or back of card): _____

Note: Your signature is an acknowledgment of understanding about the information detailed on this form.

Name: _____
Signature: _____
Date: _____