



Agreement to Pay for Professional Services

I request that therapist, Niki Picogna, LCPC, keep a copy of my credit card on file as long as she provides professional counseling services to (patient name) _____, who is my (relationship) _____.

I agree to pay the fee of \$150 for an hour session of these services. My credit card will be charged within 24 hours of a session. I am aware that clients are obligated to give 24 hours notice for cancellations and agree to be held financially responsible for the cost of the missed session if less than 24 hours notice is given, except for emergency situations (to be determined by clinician).

I agree that I am responsible for the charges for services provided by this therapist and authorize the billing of the below card for services rendered. The form will be kept in a secured and locked facility.

Name on Card: _____

Billing Address: _____

Visa

Mastercard

Discover

American Express

Card# _____

Exp. Date _____ Security Code _____

Signature: _____ Date: _____