The Clinic @ the Montgomery
The Pastoral counseling center of western kentucky
Dr. Jonathan eric carroll, klpc
CLINICAL DIRECTOR
healing . peace . life

Payment Contract
for **Services Provided** by
The Clinic @ The Montgomery

Please Note:** ***24 Hour Cancellation Policy – Please be advised that 24 hours notice is required for cancellations. Otherwise, you will be charged for the full amount of the session. Thank you for your cooperation.

Name(s):_____

Address:_____City:_____ State:_____ Zip:_____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One **Fees for Professional Services**

I (we) agree to pay The Clinic @ The Montgomery, hereafter referred to as The Clinic, all fees associated with services provided in the areas of assessment, evaluation, testing, group counseling, and individual, family, and relationship counseling. Fees for each service are as follows:

A fee of $50 per person per session is charged for all Group Therapy.
A fee of $125 per session is charged for Individual Therapy.
A fee of $135 per session is charged for Couples Therapy
A fee of $150 per session is charged for Family Therapy (Family units consisting of three or more persons).
A fee of $125 per session for all assessment and evaluation consultations.
A fee of $125 per hour for all court-related services, including but not limited to: preparation, deposition, attorney consultations on behalf of client(s), court testimony, and transportation and waiting times.
A fee of $180 is charged for therapy sessions and assessment consultations lasting one-and-a-half therapy hours, and $240 for any session lasting two hours.

Person responsible for account: _____
Date:_____

**All major credit cards are accepted, and will be charged a 3% fee upon use.*

Part Two **All Clients**

All Payments are due at the time of service, unless other arrangements have been made with The Clinic Director.

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. Additionally, in the event that I fail to pay the account balance when due, I agree to pay all collection costs including collection agency fees. I understand that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee equal to 33 1/3 of the unpaid balance will be added to my account. I agree to pay that fee. I further agree to pay reasonable attorney fees and court costs. In the event of a returned check a $25 fee will be added to client account. I understand and agree to the above terms.

Person responsible for account: ____ Date:____________________

Email Address: ____ Phone: __________________