



120 Carnegie Place, Suite 202
Fayetteville, GA 30214
404-988-9177

FINANCIAL AGREEMENT AND PROMISE TO PAY ACCOUNT

Court Attendance, On-Call, and Communication
with Attorneys/Other Professionals

For in and in consideration of court attendance, I

_____ **(client name or guardian if minor child)**

promise to pay Transcendence Child and Family Therapy, LLC (TC&FT). I understand that Transcendence Child and Family Therapy, LLC bills at the rate of \$200.00 per hour for court attendance. I agree to provide Transcendence Child and Family Therapy, LLC with my credit card information. I understand that the hourly rate begins when the therapist leaves their location. **I understand that a fee for two hours will be paid prior to court attendance, (\$400.00) and is non-refundable if less time is needed.** If the court attendance exceeds two hours, I understand that my credit card will be billed for the remaining time. In addition, I understand that I am not paying for the therapist's testimony; I am paying for their time. Therefore, the fees are expected to be paid regardless of whether the therapist testifies or not.

On call policy: I understand that if I request my therapist to be on-call for court attendance, Transcendence Child and Family Therapy, LLC bills at the rate of \$60.00 per hour for on-call. I agree to provide Transcendence Child and Family Therapy, LLC with my credit card information in order for the payment to be charged. I understand that the hours I am requesting the therapist to be on call will immediately be charged to my credit card, and is non-refundable.

Communication with Attorneys/Other professionals/Report writing: I understand that Transcendence Child and Family Therapy, LLC bills at the rate of \$100.00 per hour for any type of communication with attorneys/other professionals/report writing (phone calls, letter writing, email, consultation, etc). I understand that I will need to provide my credit card information prior to any communication my therapist will have with my attorney/ outside professional. I understand that a minimum of 30 minute increments will be billed to my credit card and is non-refundable.

Records Request For each separate request, Transcendence Child and Family Therapy, LLC bills a flat rate of \$35 for records to be copied and faxed/given to the client. If records need to be mailed, an additional fee of \$10 is assessed to cover certified mail and postage. After payment is received and processed, please allow up to 7 business days for

copies to be provided and/or mailed. I also understand that no disability paperwork, work leave of absence, FMLA, etc will be completed before the third (3rd) session.

I further understand that no records (written or verbal) will be released to me or on my behalf if I have an outstanding balance due to TC&FT. I understand that I am financially responsible for all charges and TC&FT has the right to seek legal action to receive payment for this agreement, relative to payment fees, TC&FT shall be entitled to reasonable attorney fees and cost of collection.

By signing below, I am agreeing to the terms and conditions of this financial contract.

Signature

Date

Witness

Date