Laurie Friesen, LMFT
20412 Brian Way, Suite 1
Tehachapi, CA 93561

FORM OF PAYMENT

CLIENT NAME (or parent if minor**):_____________________________________** **DATE:____________**

The client (or parent if minor) is financially responsible for services provided. As a courtesy, Laurie Friesen, LMFT will bill your insurance and accept the contracted rate as payment in full. Any co-pays, late cancellation fees, missed appointment fees, or any other fees not covered by your insurance will be paid with the form of payment on file. Payment is due when services are rendered. The form of payment provided below will be billed and a receipt will be emailed to you at:

Email address:____

FEE SCHEDULE

Service Provided	**Fee**
Initial Assessment (90791)	$100.00
Individual, Couple, or Family (90834, 90847)	$75.00
No Call No Show	$65.00
Late Cancellation (prior day notice)	$25.00
Phone Session	$25.00 per 15 minutes
Emergency or Extended Session	$100 per hour
Letter (requested by client)	$25.00
Copies of Records	$1.00 per page
Depositions (including travel)	$150 per hour

Type of card: _________________________ **Card Number:_______________________________**

Exp. Date:_______________ **CVV Code:______________**

I have read and fully understand I am financially responsible for services provided as described above.

____ ____
Client/Parent/Guardian Name (print) Client/Parent/Guardian Signature

____
Date