Changes Counseling and Mediation, LLC

Please return the signed form below, including card information if applicable.

Professional Services Contract

I/we hereby request professional services from Angela Sullivan, MA, of Changes Counseling and Mediation, for myself/ourselves or for those under my/our legal responsibility. This agreement remains in effect as services are provided or until terminated by request.

I/we agree to remit payment according to the fee schedule in the ***Practice Policies*** section. Missed appointments will result in a $80 charge as outlined. I/we accept full financial responsibility for all services rendered and understand that a debit/credit card number will be maintained for billing missed appointments only. **24 hours' notice is required to avoid a $80 cancellation fee. After three "no shows" or late cancellations (less than 6 hours' notice), the therapeutic relationship may be terminated.**

Credit/debit card #_____

Zip code: _____Code on back: _____

Payment is due at the time of service. I/we acknowledge liability for service amounts and any related collection or legal fees.

I/we confirm receipt and acceptance of the Practice Policies and Professional Disclosure Statement.

For minor clients, general information may be shared, but certain details may be held confidentially if deemed in the child's best interest.

I/we consent to card charges per cancellation policy and concur with the provisions above:

Name: _____ Date: _____

Name: _____ Date: _____