Fees are based on income and family size. The therapist has the authority to negotiate the fee scale with

the client as needed.

1. This agreement is entered into by Rebecca Van Tassel, LCSW and \_\_\_\_\_\_\_\_\_\_\_\_\_\_(responsible party.) Please check if the responsible party is □ self, or □ legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

2. Rebecca Van Tassel, LCSW, agrees to provide the following services as indicated:

\_\_\_\_a. individual, couples or family counseling: 55 minute sessions

\_\_\_\_b. group therapy: 90 minute sessions

\_\_\_\_c. group therapy: 75 minute sessions

\_\_\_\_d. other:

The responsible party agrees to the following:

a. To provide payment of □ copayment, □ coinsurance, □ $\_\_\_\_\_\_\_\_\_ per counseling session

due □ at the time of service, or □ billed monthly, as decided upon by the responsible party

and the therapist.

b. To provide adequate notice (at least 24 hours prior to the appointment) of cancellation of a

scheduled appointment or to provide payment for the scheduled time. The late

cancellation/missed appointment fee is $100.

c. To provide full payment of unpaid balances before resuming services. Any balance unpaid longer than 30 days will be billed to you.

d. To inform Rebecca Van Tassel, LCSW of any changes to income, family size, or contact information (name, address, phone numbers, emergency contact.)

e. More than 3 consecutive absences of scheduled appointments without notice and you will be

considered administratively discharged from services.

3. This agreement is effective as of \_\_\_\_\_\_\_\_\_\_\_\_ (date). This agreement will remain in effect until a

new fee agreement is signed. Fees for services are due upon receipt of services, unless otherwise

agreed upon by the therapist and responsible party. Checks should be made payable to:

Rebecca Van Tassel, LCSW. 3355 Bee Caves Road, Suite 605. Austin, TX 78746

I have carefully reviewed the above fee schedule, received satisfactory answers to my questions about it, and agree to pay for services according to this schedule.

I agree to pay for the services rendered regardless of insurance coverage, including any amount not covered by insurance.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Printed Name Date