Professional Services Contract

I/we do hereby request that Angela Sullivan, MA of professional services to me/us	
or to for whom I am legally responsible. This relation	
provides services or until I/we request in person or telephone that this is no longer my/our desire.	
I/we agree to pay Mrs. Sullivan the appropriate fee which coincides with the fee schedule presented in the <i>Practice Policies</i> section. If I/we miss a scheduled appointment, I/we understand that I/we shall be charged as set forth in the Practice Policy, a \$60 charge. I/we understand that I/we am/are financially responsible for this account. We understand that Mrs. Sullivan takes cash, credit card, and debit card. I/we understand that a debit or credit card number will be kept on file for sole purpose of billing for a missed appointment. 24 Hours' notice must be given or your card will be charged the \$60 fee. After three "no shows" or late cancellations (Less than 6 hours' notice, I may choose to terminate our therapeutic relationship.	
Credit/debit card #	
Expiration date:zip o	code:code on back:
I/we understand that payment is due at time of service. I/we acknowledge that I/we shall be held accountable not only for the service amount, but also for any associated collection or legal fees.	
I/we have read and received a copy of the Practice have read them and agree to cooperate with and a	e Policies and Professional Disclosure Statement. I/we abide by all of the provisions therein.
I/we understand that if the client is a minor, I/we may have a right to general information; however, there may be some information shared that may be held in confidence if it is in the best interest of the child.	
I/we agree that our card on file will be charged the \$60 fee if I/we do not give 24 hours' notice of cancellation.	
I/we agree to all the above:	
Name:	Date:
Name:	Date: