



TRADEPORT COUNSELING AND MEDIATION ASSOCIATES  
200 INTERNATIONAL DR. STE 157  
PORTSMOUTH, NH 03801

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[WWW.TRADEPORTCOUNSELING.COM](http://WWW.TRADEPORTCOUNSELING.COM)

**TCMA STAFF**

**AGREEMENT FOR PAYMENT OF SERVICES  
Credit Card on File**

Tracey Tucker, LCMHC

I \_\_\_\_\_ agree to pay **Tradeport Counseling and Mediation Associates, PLLC (TCMA)** the amount of \$150.00 for each scheduled or arranged counseling session. This payment is due at the conclusion of each session unless prior arrangements have been agreed to by the provider. I understand that if I wish to utilize my insurance benefits for psychological services, I may do so, but that I am expected to remit my co-pay and/or deductible at the time of service.

Kit McCann, LMFT

I authorize TCMA to:

1. Charge the credit card on file for co-pays and/or deductibles after a session with either my spouse, my child or myself \_\_\_\_\_ (Initials)
2. Charge any unpaid portion of my patient responsibility 30 days after my session to the credit card on file \_\_\_\_\_ (Initials)
3. Send all billing invoices and receipts to the email listed below \_\_\_\_\_ (Initials)

Hayley Ringwood, LCMHC

M. Kate Knight, LICSW

TCMA will charge the full hourly rate, insurance deductible or the co-pay at time of service, or after 30 days, as agreed upon by my provider. The following information can be held on file with TCMA in my records:

Lauren Gulla, LICSW

**Name on card:** \_\_\_\_\_

**CC#:** \_\_\_\_\_

**Exp. Date:** \_\_\_\_\_

Amanda Cortese, LCMHC

**CCV#:** \_\_\_\_\_

**Zip Code:** \_\_\_\_\_

Christina Baldiga, APRN

**All invoices and receipts will be emailed to me at the following address:**

\_\_\_\_\_

This information will expire as of, \_\_\_\_/\_\_\_\_/\_\_\_\_ at which point, my credit card information will be properly deleted.

**Clients with any unpaid balances after 60 days may have services terminated or suspended.**

I have read the above agreement and understand my responsibilities as set forth in this said agreement and will abide with the said terms as stated above. Your signature authorizes TCMA to charge your credit card on file for the above stated terms.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Client Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Clinician Signature: \_\_\_\_\_