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

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WWW.TRADEPORTCOUNSELING.COM

AGREEMENT FOR PAYMENT OF SERVICES
Credit Card on File

I _____agree to pay **Tradeport Counseling and Mediation Associates, PLLC** (TCMA) the required hourly amount for each scheduled or arranged psychiatric 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 psychiatric services, I may do so, but that I am expected to remit my co-pay and/or deductible at the time of service.

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)

Hourly Rates are the following:

Initial Psychiatric Evaluations: $250/Hour
Medication Checks: $100-$150/session depending on time and services rendered

The following information can be held on file with TCMA in my records:

Name on card:_____

CC#:_____

Exp. Date:_____

CCV#:_____

Zip Code:_____

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

_____

This information will expire as of, _____/_____/_____ at which point, my credit card information will be properly deleted. This information will be kept confidential private.

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:_____