



The Therapy Corner Counseling & Consulting, PLLC
6671 Southwest Freeway, Suite 427 Houston, Texas 77074
Office (832) 287-8502 | Fax (713) 354-3499

Acknowledgment of Payment Policies and Appointment Terms

I acknowledge and agree to the following terms regarding my appointments and payment obligations with The Therapy Corner Counseling & Consulting, PLLC:

1. **Late Cancellation Fee:** I understand that if I fail to cancel my appointment with at least 24-hour notice, I will be charged a *Late Cancellation Fee* of \$25.00. Under certain circumstances, the therapist may waive this fee at their discretion.
2. **No-Show Fee:** I understand that if I fail to attend my scheduled appointment without providing notice, I will be charged a *No-Show Fee* of \$50.00.
3. **Service Charge:** I understand that a *Service Charge* of \$10.00 will be applied if I fail to make my payment or co-payment at the time of my appointment.
4. **Payment Responsibility:** I acknowledge that I am responsible for knowing the total amount due for my sessions, including any applicable co-pays, fees, or out-of-pocket expenses. I understand that these charges are not covered by my insurance carrier and are my responsibility to pay.
5. **Payment Policy:** I understand that payment is required before the start of my session. If payment is unsuccessful at the time of check-in, I acknowledge that I will receive a text message link to submit payment. I further acknowledge that additional time will not be provided to accommodate delays caused by the payment process after the session begins.
6. **Medicaid and Medicare Clients:** I acknowledge that after one missed appointment without proper notification, I will no longer have the ability to schedule future appointments.
7. **Late Cancellation for Insured Clients:** I understand that if I cancel my appointment late, I will be billed the price of my copay. If no copay is required, I will be billed at the self-pay rate of \$25 for late cancellations and \$50 for no-shows.
8. **Session Duration:** I understand that therapy sessions will last between 30 and 60 minutes, depending on the type of appointment. If I arrive late to the session, I acknowledge that the session will still end at the scheduled time.\

9. I acknowledge and agree to The Therapy Corner's fee schedule as outlined below:

INDIVIDUAL THERAPY **\$135**

COUPLES/ GROUP **\$220**

Deposit Fee: \$100

Insurance will not be accepted.

NO-SHOW APPOINTMENT **\$50**

LATE CANCELLATION **\$25**

Less than 24 hours notice.

FMLA PAPERWORK **\$75**

Processed within 7-14 business days.

EXPEDITED FMLA PAPERWORK **\$100**

Processed within 3-7 business days.

FORM/LETTER COMPLETION **\$40**

3-5 business days turnaround time.

EXPEDITED FORM/LETTER **\$65**

Processed within 3-7 business days.

No reimbursements will be issued unless a duplicate payment is received from your provided insurance company.

By signing below, I confirm that I have read, understand, and agree to the terms outlined above regarding payment and attendance policies for services provided by The Therapy Corner Counseling & Consulting, PLLC.

Client Name

Signature of Responsible Party

Date