DOCHAS
Psychological Services Inc.

# Payment Agreement

**Name:**

***Payment for services is required prior to each appointment.*** Cash, Visa, Mastercard, E-transfer, and Cheques are accepted. Receipts will be issued for benefit plans and tax purposes. Exceptions should be discussed in advance with your counsellor.

Service fees are based on the standard fifty (50) minutes of counselling/assessment time and ten minutes administration/recording time.

**Hourly Rate:** **$190.00 (Individual Session/Family or Couples Session)**

Cancellation or re-scheduling requires twenty-four (24) hour advance notice. I will invoice for the hour (190.00) if I do not receive the twenty-four (24)hour cancellation/re-scheduling notice. For notice occurring less than twenty-four (24)hours, a $75.00 fee will be charged (except in case of emergency or arrangement with me).

Please initial here _____ to indicate acknowledgement of the cancellation/re-scheduling policy.

Please provide your credit card information to be kept on file. This will only be used in cases of late cancellation or insufficient coverage from insurance companies.

Card Number Expiry CVV

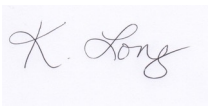
Please speak with me if you have any questions about billing policies.

I want to provide you with the best possible service. Please let me know if you have any concerns or special needs.

I accept services from Kim Long under these terms and conditions, which have been reviewed with me. I accept personal responsibility for missed appointments and any billings not payable by third party coverage (i.e. insurance).

I have agreed to submit this policy by electronic means. By signing this policy electronically, I certify that I understand the questions and statements on this policy, I have read and understand the legal information, and I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature.

Signature Date



K. Long, MC, CCC, R. Psych

Please complete the following for your practitioner to direct bill:

I have coverage through:

Chambers of Commerce ☐
Cowan ☐
First Canadian ☐
IA Financial ☐
Johnston Group ☐
Maximum Benefit ☐
Veterans Affairs ☐
ASEBP ☐

CINUP ☐
Desjardins ☐
Great West Life ☐
Johnson ☐
Manulife ☐
SunLife ☐
Alberta Blue Cross ☐
Green Shield ☐

Other:

My coverage limit is per session

My coverage limit is per year

DOB:

Identification number:

Group Number:

Section Number:

Issue Number:

Carrier Number:

I understand by completing this form I give my therapist (Kim Long) permission to submit on my behalf. I accept responsibility for any payments not covered by my insurance provider and allow Kim Long to bill my credit card for this and the cancellation policy purposes.

Signature Date