

Pathways Therapy and Wellness Center

2298 W Horizon Ridge Parkways, #201
Henderson, Nevada 89052
Phone (702) 363-7284 Fax (702) 242-5252

Fee Agreement

Name: _____ SSN: _____

I agree to pay the amount of \$ _____ per session at the time of the appointment.

Should I be unable to make my scheduled appointment and fail to give Pathways Therapy & Wellness Center a minimum of 24 hours notice, I understand that I will be charged the full session fee which will be charged on my credit card. If you are using your insurance policy, you will be billed a \$60 fee for the missed session. **Please note, I do enforce this policy.**

Signed: _____ Date: _____
Client or parent/guardian

Signed: _____ Date: _____
Therapist

Credit Card Authorization-(VISA or MasterCard Only)

Type of Card: _____
Cardholder's Name: _____
Account #: _____ Exp. Date: _____
Authorization Signature: _____

I give Pathways Therapy & Wellness Center full authorization to charge my credit card regarding missed or canceled appointments.