

**Gale & Associates, PLLC.
Psychotherapy and Assessment Services**

2760 W. Rasmussen Rd., Bldg D, Suite 210 · Park City, Utah · 84098

PATIENT/ GUARANTOR FINANCIAL AGREEMENT

1.) LATE CANCELLATION/MISSED APPOINTMENTS:

I (the undersigned) understand that if I will not be able to come to an appointment, I am required to give a full **24** hours notice of cancellation prior to the scheduled appointment time. A cancellation notice can be delivered via: cell (801-230-3205), office (435-645-9237), email: max@galeandassociates.net. In the event that I do not give said notice, I specifically agree to pay a fee for the missed appointment in the amount of **\$125 for a session (45-60 min.), and \$150 for a session (75min. or greater)**. I understand that it is my financial obligation to pay this fee within two weeks of the missed appointment date and third party reimbursement (e.g. insurance) of the cancellation fee is not possible. I understand that by signing below, I agree to the terms and conditions listed above.

Signature

Date

2.) RETURNED CHECKS:

I (the undersigned) understand that in the event that there is a returned check, I specifically agree to pay a \$35.00 returned-check fee, in addition to the original payment amount, due within 2 weeks of the original payment date. I understand that by signing below, I agree to the terms and conditions listed above.

Signature

Date

3.) RECOVERY OF INCURRED CHARGES:

I (the undersigned), understand that once my account is 30 days late, a flat service fee of \$6.75 per month will be applied to my account. I understand that this charge is a billing service charge, and cannot be removed once it has been applied. I also understand that If my account reaches 90 days past due, it will then be immediately turned over to a collection agency. In the event legal action is taken to collect on the account, I specifically agree to pay all reasonable attorney's fees and court costs. If the account is referred to a collection agency or attorney for collection, I further agree to pay an additional amount representing fifty percent (50%) of the principal balance. This additional amount is in recognition of the costs associated with said collection action processing.

Signature

Date

4.) ACCEPTANCE OF TERMS OF FINANCIAL RESPONSIBILITY

I understand that by signing below, I agree to the terms and conditions listed above. Any fees/charges incurred are payable to Gale and Associates, LLC.

Signature

Date