Updated 7/28/2020

Best of Me Counseling & Therapy, PLLC

Chandra Lasley, Ph.D., LMFT

Individual, Couple, and Family Therapy | EMDR Therapy

7733 Ballantyne Commons Pkwy Ste 201-C

Charlotte, NC 28277

Phone: (704) 486-2541 | Fax: (704) 519-2582

Fee Agreement

1. I ask that payment be made at each visit, unless other arrangements are agreed upon in advance. Also, you are responsible for monitoring limitations to your insurance policy when submitting out-of-network claims.

   For adolescent visits, the parent accompanying the adolescent will be financially responsible unless I am notified in writing by another party who accepts this responsibility.

   For couple therapy, both partners are financially responsible. Therefore, if you are paying with a credit card, I will request both partners' credit card information. We will also establish who will be primarily responsible for payments. If the primarily responsible partner is unable to pay, I will automatically bill the other partner.

2. I will make every effort to work out a suitable payment plan with you. I ask that you adhere to the contract you establish and notify me if the payment contract needs to be renegotiated.

3. Appointments which are not kept OR which are cancelled without a 24-hour notice will be charged at the session's regular fee and cannot be billed to your insurance.

4. If I do not receive payment for 2 sessions in a row, I will not schedule another appointment until the balance is resolved.

5. I accept payment in the forms of cash, check, and credit card. If you choose to use a credit card, I use Simple Practice— a HIPAA-compliant electronic health record system that securely stores credit card information— to process the payment.

6. A $10 service charge will be charged for any returned checks.

Agreement

I, the undersigned, guarantee payment for services rendered by Dr. Chandra Lasley. I understand that I am responsible for the entire balance regardless of my insurance coverage.

_____ _____

Client/parent or managing conservator Signature Date

_____ _____

Therapist Signature Date

Please **do not** e-mail this document.

This document can be returned to me in-person or sent through fax: (704) 519-2582