THE SANDHURST CENTER

OUTCOME FOCUSED TREATMENT

FINANCIAL AGREEMENT AND PROMISE TO PAY ACCOUNT

For and in consideration of services rendered and to be rendered to ______________________________

__________________________________, I will promise to pay The Sandhurst Center,LLC. I understand that the total charges are due when services are rendered. For and in consideration of court attendance, I will promise to pay The Sandhurst Center, LLC.

I understand that The Sandhurst Center, LLC bills at the rate of $200.00 per hour for court attendance. I agree to provide The Sandhurst Center, LLC with my credit card information. I understand that the hourly rate begins when the counselor leaves the office location. I understand that a fee for two hours will be paid prior to court attendance, ($400.00) and is non-refundable if less time is needed. If the court attendance exceeds two hours, I understand that my credit card will be billed for the remaining time. In addition, I understand that I am not paying for the counselor testimony; I am paying for their time. Therefore, the fees are expected to be paid regardless of whether the counselor testifies or not.

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(initial)

I understand that my credit card will be charged for any time that my counselor has to spend dealing with legal issues (responding to subpoenas/ court orders, phone conversations, letter writing, etc.). I understand I hold COMPLETE financial responsibility for any legal fees that my counselor incurs due to myself or my MINOR child (even if I am not the one making the request). I understand that ALL fees will be paid prior to my counselor responding to any legal issue and that I am paying for my counselor TIME and not RESPONSE. I understand that my credit Card will be charged a minimum of $50.00 for any communications and any time that exceeds 30 minutes will be charged an additional $50.00 ______________(initial)

I understand that I am financially responsible for missed appointments, in which I do not give a 24-hour notice. Notice must be given via phone call. The fee for a missed visit (in which less then 24-hour notice is not given) is $75.00. This fee will be expected upon arrival of your next visit or charges to the credit card on file, before services are rendered. _________________(Must initial)

I understand that I am financially responsible for all charges at the time services are rendered. I understand if I do not pay the entire amount due to The Sandhurst Center,LLC. I hereby agree and give my permission to The Sandhurst Center, LLC, to seek legal action to receive payment for services rendered and or work with The Sandhurst Center's preferred collection agency to resolve payment. I understand that I will be responsible for paying the collection and/or legal fees should my account be turned over to collections. I also agree that in the event it is necessary to retain an attorney to enforce the terms of this agreement, relative to payment of fees, The Sandhurst Center, LLC shall be entitled to reasonable attorney fees and cost of collection.___________(initial)

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Please provide us with your credit card information. The card will ONLY be charged if less than 24 hr notice is given to cancel an appointment or on accounts in which insurance did not pay or a balance is due.

Type of Card (Visa, Mastercard, Amex, Discover):	Card#:
Name as it appears on card:	Zipcode:
Expiration:	3 Digit Security Code:

By signing below I am agreeing to the terms and conditions of this financial contract.

____ ____________________

Signature Date

2022 The Sandhurst Center, LLC