South Charlotte Counseling and Psychotherapy, PLLC
Jumana S Scoggins, MA, NCC, LPC

Financial Policy

By initialing next to each statement and signing below, I acknowledge that I have read and accept the financial policy of South Charlotte Counseling and Psychotherapy, PLLC.

_____I understand that I am responsible for full payment of services at the time of service.

_____I understand and agree to pay a $50 charge for the first 2 late cancellation (less than 24 hours) or no-show appointments. I understand that a 3rd late cancellation or no-show will be charged at the full rate.

_____ I understand that it's important for therapy to attend regularly and that after a 3rd late session or missed appointment, the therapeutic relationship may be terminated

_____I understand that my credit card information will be requested and kept on file by IVY, a confidential and HIPAA compliant online payment system, to charge any balances.

Mobile phone number: ________________________

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CLIENT/GUARDIAN SIGNATURE **DATE**