Dr. Irit Goldman, PsyD. MFC46437
Licensed Marriage and Family Therapist
1604 Ford Ave, Suite 1
Modesto, CA. 95350
Tel: (209)605-9626
Fax: (209)577-3412

Fee Agreement

I agree to pay Dr. Irit Goldman $ _____ per session as agreed upon before the commencement of therapy services. I understand that the fee for services can be paid in cash, cashiers check, or via credit card. I understand personal checks are not accepted. I understand that payment for the session is due at the time of the session, unless other arrangements have been made by Dr. Irit Goldman, LMFT and myself prior to the session. I understand that if I pay with a credit card, there is a $5.00 fee in addition to the base fee, for fee processing.

I understand that I am responsible for the payment of the above fee if I do not show up for a scheduled appointment, or cancel less than 24 hours before my appointment time.

I authorize Dr. Irit Goldman, LMFT to charge the credit card listed on this form, if I do not show for a scheduled session, or cancel less than 24 hours before my scheduled appointment time:

Type of card: Visa/ Mastercard/ American Express/Discover (circle)

Credit card number _____ Expiration: _____/_____

CCV code (3 digits on back): _____ Zip Code on card: _____

I would like a receipt emailed to this address: _____

I would like a receipt texted to this phone number: _____

I understand that Dr. Irit Goldman, LMFT will make reasonable attempts to collect session fees that are owed if I fail to pay them at the time of session or as agreed. I understand that it is both legal and ethical for Dr. Goldman to turn over my unpaid balances to a third party for collection if I fail to pay my fees within a reasonable amount of time (no more than 60 days from the date of the service). I also understand that I am responsible for the payment of the full above fee, if I do not show up for to a scheduled appointment or cancel less then within **24** hours of my appointment time, unless arrangements have been otherwise agreed to by myself and Dr. Irit Goldman, LMFT.

I acknowledge receiving a copy of this agreement.

_____ _____ Date: _____

Print Name Signature

_____ _____ Date: _____

Print Name Signature