Dr. Jennifer Rubolino, LMHC
5300 W. Atlantic Ave., Suite 408
Delray Beach, FL 33484

~~Fee Agreement~~

I understand I am solely responsible for payment in full at the time of service. I understand that appointments cancelled **within 24 hours** of the scheduled time will be billed at the full private session fee. Missed sessions will be charged to the credit card I have provided below. A therapy session is defined as a 50-minute session**.**

_____ _____

Client Name Date

_____ _____

Signature Date

_____ _____

Client Name Date

_____ _____

Signature Date

Credit card Number _____

Expires_____ Security Code_____ Zip Code: _____