



*Risa L. Davis-Ganel, LCMFT*  
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### FINANCIAL AGREEMENT

Please understand that you are financially responsible for your treatment and that payment is expected when services are rendered.

How would you like to pay for services today and future visits?

Please initial below:

\_\_\_\_\_ Cash

\_\_\_\_\_ Check (please make check out prior to your session to Risa Davis-Ganel)  
(See General Policies for returned check policy)

\_\_\_\_\_ Visa    MasterCard    Discover (Please Circle)

Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

I authorize Risa Davis-Ganel, LCMFT to use my card for payment of ongoing sessions, including no-shows and cancellations without 24 hours notice, until discharge or my request to stop billing.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

You will be provided with an invoice to obtain reimbursement from your managed care or insurance company or to be used for tax deduction purposes upon request.

**If method of payment chosen above is Cash or Check the following is required:**

In the event that there is a missed appointment, a no-show or a cancellation without 24 hours notice, I authorize Risa Davis-Ganel, LCMFT to use the credit card below for payment.

\_\_\_\_\_ Visa    MasterCard    Discover (Please Circle)

Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I have read and agree to all above-mentioned items.

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date