Agreement to Pay for Professional Services

I, the client (or person acting for the client), request that the therapist named below provide

professional services to me or to _____ , who is my

_____, and I agree to pay this therapist's fee of $ __145.00__

per session for these services and plan to pay at the time of service unless other arrangements have been explicitly agreed upon. I have filled out the credit card information form and give Dr. Abbott sole permission to debit my credit card for sessions or services not paid for by me directly at the time services are rendered.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail that I wish to end it. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

It has been made clear to me that therapy sessions are 50 minutes in length unless otherwise specified, and that non-emergency phone contacts (if initiated by client only & excluding basic logistic/scheduling/cancellation calls) as well as collateral services such as the participation of my therapist in school PPTs, letters provided to schools or other agencies, or client-requested consultations with other professionals not directly indicated by my child's treatment needs, etc., will be billed separately.

I agree that I am solely responsible for the charges for services provided by this therapist to me and/or my child, although Arete Psychological Associates will generate itemized bills on request that I may submit to other persons, agencies, or insurance companies to obtain reimbursement. Please be advised that Arete cannot guarantee any level of reimbursement from your carrier though we will do my best to assist families in the process.

I understand that if I/my child will miss an appointment for non-medical reasons, I will be billed if I do not provide at least a 24-hour notice of cancellation.

_____

Signature of Client, Parent (or legal guardian of client) Date

_____

Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____

Signature of therapist Date

☐ Copy accepted by client ☐ Copy kept by therapist

Agreement to Pay for Professional Services