ASSOCIATED PSYCHOLOGISTS - PATIENT AGREEMENT FORM

T: (949)716-5150

FEES ARE QUOTED BY THE SESSION

Individual Psychotherapy or Marital Therapy	$ 180 – 300 per hr.
Family Therapy	$ 180 – 300 per hr.
Reports, Letters, Misc.	$ 150+ per document

INDIVIDUAL PSYCHOTHERAPY, MARITAL COUNSELING, AND FAMILY THERAPY SESSIONS ARE SCHEDULED FOR 45 – 50 MINUTES. SESSIONS MUST BE CANCELLED 72 HOURS IN ADVANCE OR A CHARGE EQUIVALENT TO A REGULAR SESSION WILL BE ASSESSED.

PAYMENT OF FEES

Full payment of fees is to be made at the time services are rendered. A fee of 5% per month may be added monthly to add outstanding accounts in excess of thirty (30) days, and will increase until collected. A $25.00 service fee will be charged for any checks that are returned from your bank.

INSURANCE

Your superbill will contain all the necessary information for you to be reimbursed from your insurance company.

CONFIDENTIALITY OF INFORMATION

All written or spoken material from any and all sessions will be considered confidential, unless you give written permission to release all or part of this information to a specific person or agency. Exceptions to this confidentiality involve cases where the law requires a licensed therapist to report instances of child neglect/abuse and where there may be imminent physical danger to one's self or others. In addition, it is understood that cases are sometimes discussed among the professional staff for educational and research purposes.

DELINQUENT ACCOUNTS

If accounts become delinquent past thirty (30) days, our office will begin collection procedures. We will attempt to contact you by mail or by phone, however, if your account remains delinquent past thirty (30) days, an outside agency and/or small claims court action may be taken. In such cases, non-clinical information (as given on the Non-confidential Questionnaire) regarding this account will be exchanged.

If any of the above provisions are not satisfactory, please make alternate arrangements prior to or during your first therapy appointment.

Please sign to indicate you have carefully read and agree to the above conditions.

_____ _____

Client's Signature Date

_____ _____

Therapist's Signature Date