**Agreement to Pay for Professional Services**

I request that Dr. Marc L. Feldman provide professional services to me, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who is my \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and I agree to pay this psychologist’s fee (see fee schedule below), or if using insurance, I agree to pay the copay, coinsurance, or deductible.

I agree that this financial relationship with this psychologist will continue as long as the therapist provides services or until I inform him 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. **I also agree to pay a fee of $50 if I (or the client) do not attend a scheduled appointment without giving 24 hour notice, in person, by phone, or by email.**

I agree that I am responsible for the charges for services provided by this psychologist to me (or this client), although other persons or insurance companies may make payments on my (or this client’s) account. **I agree to provide payment at the time of service, and if I do not, I understand that I will be charged a $5 late fee. I understand that if I choose to pay for these services by writing a personal check, I will be charged a fee of $25 if the check is returned for insufficient funds.** I also understand that if I am using insurance and my policy is terminated, or the information that I provided is incorrect, I am responsible for the full fee of any services that are rendered.

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Signature of client (or person acting for client) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name

I, the psychologist, 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marc Feldman, Psy.D., PA Licensed Psychologist Date

License Number PS016917

❑ Copy accepted by client ❑ Copy kept by therapist

\*Fee Schedule:

Initial Evaluation/Assessment: $150

1 Hr individual session: $150

45 minute session: $120

Family or Couples Session:$150