Standish McCleary III, J.D., Ph.D. **Licensed Psychologist**

Services & Fee Agreement

PLEASE READ & INITIAL AT CHECKED BOXES

Client ____

Services

I understand that the services to be provided include:

[X] ______ Psychotherapy/Counseling [X] ______Consultation

Informed Consent I understand that the information and communications shared as part of the services provided are:

Fees for Services / Payment policies

[X] ______ Intake Fee, including initial interview, and billing set-up is $ 200 and generally the sessions last 75 minutes.

[X] ______ Psychotherapy/Counseling services are payable at $140 per 45--50 minute session, $165 for 60 minutes,, & $200 for 75 minutes.

[X] ______ Consultation is billed at $165 per hour, and travel time may be billed.

[X] ______ Preparation of reports or letters will be billed based on the contracted hourly or session rate.

[X] ______ Court or legal testimony; preparation, travel and waiting time, will be billed at $250 per hour plus expenses.

[X] ______ **Missed appointments may be billed at the full hourly or session charge if I do not give 24 hours notice of intent to cancel.**

[X] ______ **I understand that payment for services is due at the time of service and the responsibility for payment is mine.**

Payment Agreement

[X] ______ I intend to pay in full at the time services are rendered. My credit card will be charged for any payment 30 days in arrears.

[X] ______ Provide a statement I can submit for reimbursement by a third party. (insurance or cafeteria plan) (Complete **Consent** form)

[X] ______ Charge my credit card for each date or unit of service at the time of service.

Third Party Payment – Billing Agreements

[X] ______ **I agree that denial of payment by my insurance carrier or other third party does not waive my responsibility to pay.**

[X] ______ I elect to have an insurance carrier or other third party billed on my behalf. I authorize that any balance outstanding 90 days after billing will be charged to my credit card*. **If subsequent third party reimbursement results in a credit balance to my account with Standish McCleary Ph.D. that credit can be refunded to me by check within 30 days of receipt or retained as a credit in my account.***

[X] ______ Charge my credit card for co-payment and deductible charges not covered by my insurance plan.

CREDIT CARD INFORMATION – REQUIRED FOR ALL PAYMENT PLANS

I authorize Standish Mccleary Ph.D. to charge this account for services according to the payment plan agreed above:

Card Number: ________________________________ **Visa** _____ **MasterCard** ____ **Expires: Mo:**_____ **Year:** _____ **Security Code:** ________

Client Signature: ____

Card holder name if other than Client receiving services: ____

Card holder address if other than Client: Street, City, State, Zip: ____

Signature of card holder or responsible party (if other than client): ________________________________ Date: ____________