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:

0 _____ Psychotherapy/Counseling 0 _____Consultation

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

Fees for Services / Payment policies

0 _____ Intake Fee, including initial interview, and billing set-up is $ 200 and generally the sessions last 75 minutes.

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

0 _____ Consultation is billed at $165 per hour, and travel time may be billed.

0 _____ Preparation of reports or letters will be billed based on the contracted hourly or session rate.

0 _____ Court or legal testimony; preparation, travel and waiting time, will be billed at $250 per hour plus expenses.

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

0 _____ **I understand that payment for services is due at the time of service and the responsibility for payment is mine.**

Payment Agreement

0 _____ 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.

0 _____ Provide a statement I can submit for reimbursement by a third party. (insurance or cafeteria plan) (Complete **Consent** form)

0 _____ Charge my credit card for each date or unit of service at the time of service.

Third Party Payment – Billing Agreements

0 _____ **I agree that denial of payment by my insurance carrier or other third party does not waive my responsibility to pay.**

0 _____ 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.***

0 _____ 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: _____