THE PSYCHOLOGY CLINIC, Inc.

SELF PAY FORM

Account Number	Therapist	Date of Service

CLIENT	NAME Last	First	MI	Name I prefer to be called	Spouse/Partner Name
ADDRESS Street	City	State	Zip Code		Home Phone: Can we call you? --
BIRTHDATE	GENDER	MARITAL STATUS --			Cell Phone: Can we call you? --
EMPLOYER Company Name	Address				Work Phone: Can we call you? --
Emergency Contact	Relationship	Address			Phone Number
Family Physician	Clinic	Address			Phone Number

PARENT OR LEGAL GUARDIAN (if applicable)	Relationship to Client	Birth Date	Home Phone
Name Last First MI	Address		Cell Phone
EMPLOYER	Address		Work Phone

(Please Sign and Date other side)

THE PSYCHOLOGY CLINIC, Inc.

The fee for the initial consultation is _____. The fee for subsequent sessions is _____ per unit of services provided. Units are based on the amount of professional time utilized. You will be billed for all the time that is reserved for you. If additional time or services (such as telephone contacts) are provided, a pro-rated fee may be charged. There may be a charge if another agency or a third party requires a report. Failure to provide 24 hours advance notice of appointment cancellation or failure to show for an appointment may result in a charge at the regular fee. Repeated late cancellations or no shows may result in your being discharged from the clinic.

Your payment is expected at the time of service. The Psychology Clinic, Inc. will not file claims with third party insurance payers. It is assumed that this financial relationship will continue as long as services are being provided or until such time as the client notifies The Psychology Clinic, Inc. of a wish to terminate treatment. Once treatment terminates, any balance not paid in full will be considered due. If acceptable financial arrangements have not been made, The Psychology Clinic, Inc. reserves the right to utilize legal means to obtain reimbursement. This may result in releasing names and addresses to a collection agency.

My signature below indicates that I read, understand and agree to this fee policy. I will take responsibility for all charges to any account for which I am the designated responsible party.

_____ _____

Client/Legal Representative signature **Date**