AGREEMENT FORM

As an informed consumer, it is important that you understand the terms and conditions of any services that you receive. The following document describes the terms and conditions of services provided by Dr. Bob Dick and your rights and responsibilities as a client. Please discuss this form with Dr. Dick prior to signing it.

PARTICIPATION IN TREATMENT

I understand and hereby agree to service that is recommended. Any questions, concerns or exceptions will be discussed with my therapist.

I will discuss with my therapist what my problems are and will work with him on an approach to treatment.

PAYMENT AGREEMENT

I agree that I am responsible for full and timely payment of fees as described in this contract.

My clinician and I have discussed payment of my account and I understand that my professional fees are based on $_____for a ____ minute session for individuals, couples or group therapy (circle one). The fee for the initial evaluation and assessment (first session) is $_____. Fees may be periodically adjusted and I understand that I will be notified in advance of the adjustment. Psychological assessments, consultations, phone calls and reports are billed at $ _____ per _____ minute session. I understand that should I receive testing services; there will be charges beyond the time spent directly with the service provider. These fees are a result of the time spent scoring and interpreting the tests and report writing when necessary. Brief professional services are billed at $ _____ per 15 minute period or any part thereof, including telephone conversations. Services involving interfaces with the legal community (telephone consults with the attorneys subpoenas, for records, etc) will be billed at
$ _____ per hour, including travel time as necessary.

Please initial:

_____ I understand that I am responsible for paying each charge in full at the time of service.

_____ I understand that there will be a charge of $ _____ for a missed appointment or an appointment cancelled less than 24 hours in advance.

_____ My clinician and I have worked out the following payment plan. I agree to maintain this payment plan until the entire balance of my account is paid and will make co-payments for current dates of services.

_____ I agree to make payment of $ _____, or to pay $ _____ at the time of each visit.

Signature _____ Date _____

SSN _____

Therapist _____ Date _____