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## Agreement to Pay for Professional Services

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I request that the clinician named below provide professional services to me and I agree to pay this clinician's fee of \$115 per session for these services or the fee of \$145 for initial consultations.

I understand and agree that I am responsible to pay the charges for services provided by this clinician to me, although other persons or insurance companies may make payments on my account.

I agree to pay for services provided to me up until the time we end the relationship. We will discuss ending, and a date will be agreed to and recorded in this client's medical records; or I will inform the clinician, in person or by certified mail, that I wish to end it. I agree to meet with this clinician at least once before stopping therapy.

I have also read this clinician's "Information for Clients" or practice brochure and agree to act according to everything stated there, as shown by my signature below and on the brochure.

\_\_\_\_\_  
Signature of client

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client

I, the clinician, have discussed the issues above with the client (and/or the person legally 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 and able to give informed and willing consent.

\_\_\_\_\_  
Signature of clinician

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

Copy accepted by client or  Copy kept by clinician

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