



Professional Service Agreement

Patient Name: _____ DOB: ____ / ____ / ____

Notification for cancellation of a scheduled appointment is 24 hours. If timely notice is not given, you may be charged at the agreed rate. Services may be terminated due to appointment cancellations.

Services are charged at the following fee schedule. Telephone conferences may be invoiced at the appropriate fee.

Extended Diagnostic Interview	60 minutes	\$215
Diagnostic Interview	45 minutes	\$175
Individual Psychotherapy	45 minutes	\$125
Individual Psychotherapy	25 minutes	\$ 70
Family Psychotherapy	45 minutes	\$135
Psychological Testing	60 minutes	\$150
Neuropsychological Testing	60 minutes	\$200

Upon first giving notice, the terms of this agreement may be changed, modified, or altered. Any objections to such changes, modifications, or alterations must be made promptly, otherwise, agreement is assumed.

I have read, fully understand, and agree to the above.

Patient Signature

____ / ____ / ____
Date

Signature of Patient Representative/Guardian

____ / ____ / ____
Date