Georgemiller Whyte & Associates

Professional Services 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.

Diagnostic Interview	45minutes	$215
Individual Psychotherapy	45 minutes	$150
Individual Psychotherapy	25 minutes	$ 90
Family Psychotherapy	45 minutes	$175
Psychological Testing	60 minutes	$150
Neuropsychological Testing	60 minutes	$200
Letters (non-medical personnel)		$ 50

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

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