PSYCHOTHERAPY PAYMENT AGREEMENT

I, _____, agree to meet with Kristen Wright, PsyD and understand that the full fee for sessions is: $125.00. My sessions will last 45-50 minutes. I am aware that any cancellations of appointments must be made more than 24 hours before my appointment, unless it is an emergency and if I do not cancel or not show up, I will be charged for the full fee of that appointment. I agree to be financially responsible for the cost of treatment and I am aware that if I have not paid for services received or worked out a payment arrangement with Kristen Wright, PsyD, treatment may be discontinued.

Please choose one of the following options by initialing:

_____I am paying full fee for psychotherapy and am aware that I must bring cash or a check to each appointment, or keep a credit card on file with Kristen Wright, PsyD, unless other arrangements have been made.

_____I am electing to have my treatment to be paid in full or part by my insurance carrier or another third party, I will authorize this in writing and allow Kristen Wright, PsyD, to release to an authorized agent of my insurance or a third-party payer information about the type(s), cost(s), date(s) of any service of treatment I receive. I am financially responsible for any portion of the fees not covered or reimbursed by my health insurance carrier. Further, I understand that I am responsible for preauthorizing sessions before beginning treatment and if I do not receive preauthorization, I am financially responsible for those sessions not covered by my insurance.

_____ I am not able to pay full fee for therapy and I have discussed a sliding scale fee with Kristen Wright, PsyD and we have agreed upon _____per session as my fee.

I have been informed and agree to hold Kristen Wright, PsyD, harmless from any losses, damages, liabilities, costs and expenses (including and without limitation of attorney's fees) arising from the release of such information to my insurance carrier, or to a third-party payer or to any other agent as designated by me.

I am aware that the practice of psychotherapy is not an exact science and so predictions of the effect are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment provided by Kristen Wright, PsyD.

I understand that regular attendance will produce the maximum benefit, but that I am free to discontinue treatment at any time. If I decide to do so, I will notify Kristen Wright, PsyD, at least two weeks in advance so that effective planning for termination and or continued treatment elsewhere can be implemented. I am aware that I will still be responsible for payment for the services that I received.

I understand that Kristen Wright, PsyD is not providing an emergency service and I have been informed of whom and where I should call upon in an emergency or during weekend, vacations, and evening hours.

I understand that all conversations with Kristen Wright, PsyD, are confidential. I further understand that Kristen Wright, PsyD, by law, must report actual or suspected child or elder abuse/neglect to the appropriate authorities. In addition, Kristen Wright, PsyD, has a legal responsibility to protect anyone if I may threaten harmful or dangerous actions (including those actions to myself) and may break confidentiality of our communication if such a situation arises.

Name (please print): _____

Signature/Date:_____

Parent or Guardian/Date:_____

Witness/Date:_____