Payment Contract for Services

Name of Client _____Client's Birthdate _____

Client's Employer _____

Client's
Address _____
Street City State Zip

Home/Cell Phone No. _____ Work Phone No. _____

Relationship to Policy Holder (Insured): Self Spouse Child Other

Name of Insured (if different from above) _____
Insured's Birthdate _____ID Number of Insured _____
Insured's Address _____
Street City State Zip

Insurance Plan Name _____ ID Number _____
Insurance Plan's Phone number _____
Insured's Employer _____
Group Policy Number_____
Emergency Contact (name & phone number)_____

Part One Fees for Professional Services

I (we) agree to pay Sharon P. Austin, Psy.D. a rate of $ 150.00 per clinical unit (defined as 50-60 minutes for assessment, individual and relationship counseling). Sessions which go longer than the standard time period are prorated accordingly. A fee of $45.00 is charged for group counseling (defined as 60-90 minutes per group session). A fee of $30.00 is charged for a one-page treatment summary sent out to a third party (i.e., insurance). Any additional pages will be prorated accordingly. A fee of $150.00 is charged for missed appointments or cancellations with less than 24 hours' notice. There is a $20 charge for insufficient funds.

Your insurance company may not pay for services that they consider to be not medically or therapeutically necessary or ineligible (not covered by your policy). You will be responsible for full payment of non-covered services.

Please turn page over

Payments, co-payments, and deductible amounts are due at the time of service. There is a 1.5 % per month late payment charge on all accounts that are not paid within 30 days of the billing date.

Part Two Release of Information Authorization to Third Party

I (we) authorize Sharon P. Austin, Psy.D. to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to _____ for the purpose of receiving payment reimbursement directly to Sharon P. Austin, Psy.D.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) certify that I (we) have read and agree to the conditions. **Initials _____**

Part Three Consent for Treatment with Sharon P. Austin, Psy.D.

I have been explained my rights as a client, the limits of confidentiality, and the methods of treatment to be utilized. I also understand that my therapist will explain any additional procedures to be used during the course of my treatment prior to their use. I understand that these procedures will be used only at my additional consent. I also understand that I will work closely with my therapist to establish goals and determine treatment methods that will allow me to address my presenting issues in the most efficient manner possible. I am aware that my therapist can make no guarantees about the outcome of my treatment or necessarily predict all potentially uncomfortable feelings and reactions that emerge during the course of treatment. However, I am agreeing to work with my therapist when these feelings arise.

My signature below signifies that I am authorizing and requesting my practitioner carry out treatment and diagnostic procedures which now, or during the course of my treatment become recommended. It also signifies that I have read and agree to all of the above information.

_____ _____

Client Signature Date