



**IN CASE OF EMERGENCY NOTIFY (if other than above)**

NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ WORK/CELL: \_\_\_\_\_

**Payment Terms for Forensic Work**

Your insurance cannot be used for Court Ordered procedures or consultation. You will be responsible for all the costs as decreed in the Order from the Court or in the Rule 11 Agreement signed by your attorneys. Cash, money orders, checks and credit cards are accepted as means of payment.

Court appearances are not included in the total fee quoted for the consultation or evaluation unless this has been noted specifically by the psychologist. Appearances at Court are \$150 per hour, portal to portal, and require a minimum \$300 (two hour) retainer. Your signature below indicates you have read and understand this notice.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

**FOR NON-FORENSIC TREATMENT ONLY**

**PAYMENT AGREEMENT**

I AGREE TO THE FOLLOWING PAYMENT PLAN TO COVER MY PORTION OF THE CHARGES:

- \_\_\_\_\_ I DO NOT HAVE INSURANCE AND WILL PAY IN FULL AT THE TIME OF SERVICE.
- \_\_\_\_\_ I WILL FILE MY OWN INSURANCE AND WILL PAY IN FULL AT THE TIME OF SERVICE.
- \_\_\_\_\_ PLEASE FILE MY INSURANCE. I WILL PAY MY COST SHARE AT THE TIME OF SERVICE.

I UNDERSTAND THAT IF PROBLEMS ARISE IN GETTING PAYMENTS FROM MY INSURANCE COMPANY, IT WILL BE MY RESPONSIBILITY TO PAY THE BILL AND SETTLE WITH THE CARRIER UNLESS THE PROVIDER HAS OTHERWISE CONTRACTED WITH YOUR CARRIER. I AGREE TO PAY OFF ANY BALANCE ON MY ACCOUNT WITHIN 90 DAYS UNLESS I HAVE MADE OTHER ARRANGEMENTS. BALANCES OVER 90 DAYS WILL BE ACRUED A 15% INTEREST CHARGE. A \$20 CHARGE WILL BE ADDED TO YOUR ACCOUNT FOR CHECKS RETURNED FOR INSUFFICIENT FUNDS. I UNDERSTAND THAT MY ACCOUNT MAY BE SENT TO A COLLECTION AGENCY IF I DO NOT PAY MY BILL ACCORDING TO THIS DOCUMENT. IF USE OF A COLLECTION AGENCY IS NECESSARY YOU WILL BE CHARGED A 6% INTEREST FEE ON THE BALANCE AT THE TIME IT IS SENT, IN ADDITION TO A \$15 COLLECTIONS FEE.

\_\_\_\_\_  
RESPONSIBLE PARTY SIGNATURE

**MENTAL HEALTH DISCLOSURE FORMS**

**Release of Information:**

I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation, and professional communication. If I am an insured



**Consent for Treatment for Child or Dependent**

I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize the practitioner to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Social Security number

\_\_\_\_\_  
Signature of legal guardian/representative

\_\_\_\_\_  
Date