FEE PAYMENT AGREEMENT

$215.00.....50-60 mins.	Initial Diagnostic Interview
$215.00.....45-50 mins.	Individual Psychotherapy
$107.50.....20-30 mins.	Individual Psychotherapy
$215.00.....45-50 mins.	Family/Couples Psychotherapy
$215.00.....60 mins.	Testing/Evaluation (pro-rated)
$215.00.....60 mins.	Preparation of letters or reports (pro-rated)
$215.00.....60 mins.	Telephone calls/out of office (pro-rated)

(We reserve the right to charge for preparing narrative reports requested by the patient or other agency).

CONSENT FOR TREATMENT/EVALUATION

I hereby authorize **Susan C. Reeder, Ph.D.** to administer treatment and/or testing services. Payment of fees and the insurance procedures have been explained to me. I agree to pay fees at the time services are rendered. Should it become necessary to refer this account to any attorney or collection agency, I agree to pay all reasonable costs.

_____

Signature of Client *Date*

INSURANCE INFORMATION

Who is responsible for this account?_____

Relationship to patient_____Social Security# _____

Date of Birth_____

Do you have medical insurance? No____ Yes____ If Yes:

- Name of Primary Insurance Co._____
- Contract #_____ Group#_____
- Subscriber #_____
- Subscribers Name_____ Subscribers Date of Birth_____
- Subscribers Address_____

Are you covered under any of these programs?

Medicare_____ Workers Compensation_____

I.D.# for program you've checked_____

Is your condition related to employment (current or previous)? No____ Yes____

ASSIGNMENT AND RELEASE OF INFORMATION

I hereby authorize **Susan C. Reeder, Ph.D.** to release to:_____

Name(s) of Insurance Company

all information about my diagnosis and/or documentation of treatment received by me for the purpose of reimbursement. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I assign directly to **Susan C. Reeder, Ph.D.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____

Signature of Client ***Date***