

**Dawn M. Roy, LCSW
Therapist**

203-331-7458

**540 Tunxis Hill Road
Fairfield, CT 06825**

AGREEMENT TO PAY FOR PROFESSIONAL SERVICES

I, the undersigned, request that the above named therapist provide professional services to _____ as a client, and I agree to pay this therapist's fee of \$_____ per session for these services. In addition, due to the nature of work with adolescents, there is often ongoing collateral management of services (school and/or doctor correspondence, clinical evaluations sent to higher levels of care, ppts, etc.) I understand that there may be an additional charge of ½ the above rate if the time spent by the above named therapist is 30 minutes or longer within a given week. This will be discussed with the parent/guardian ahead of time and before a bill is rendered.

I understand that I am responsible for charges for services provided by this therapist to this client, although other persons or insurance companies may make payments on this client's account. Any charge not paid by my insurance company is my responsibility.

I have read the forms in the intake packet and agree to cooperate with and abide by all of its provisions as indicated by my signature there.

If the client is a minor, I understand that while I have a right to general information on issues and progress, some information shared in this professional relationship will be held in confidence by the therapist and the minor child.

If, at any time, I am dissatisfied with this therapy I will fully discuss my views, reasons and plans with the therapist (and if the client is a minor, with the client named above).

I agree that this financial relationship will continue in effect with the above named professional as long as this therapist provides services or until I inform him or her, in person, by telephone or by email that I wish to end it. I agree to pay for services rendered to this client up until the time I terminate the relationship.

Today's Date: _____ Signature: _____
Relationship to client: _____
Phone numbers/email: _____ (cell, work, home)
May I contact you at these and /or text message with you? _____

PAYMENT IS DUE AT THE TIME OF THE SESSION IN CASH, CREDIT or HSA CARD. NO PERSONAL CHECKS ARE ACCEPTED. IF YOU ARE UNABLE TO PAY AT THE TIME OF YOUR SESSION, IT IS EXPECTED THAT YOU WILL MAKE ARRANGEMENTS TO PAY FOR YOUR SESSION WITHIN 24 HOURS OF YOUR VISIT.