# Payment Agreement

**Billing Information**

Client name: ________________________________________

Social security number: ________________________________

Date of birth: ________________________________________

Person paying for the services (if different) & Relationship to client:
______________________________________________________

Phone number: ______________________________________

Home address: ______________________________________

Email: ____________________________________________

**Payment Information**

Payment method: Self-pay Insurance
Insurance company: ____________________________________________
Name of person on Insurance (self/parent/spouse): ________________________
Insurer's Date of Birth: ______________ Employer / University: _____________
Policy number: ____________________ Group number: ___________________

Clinical rate per session: $200.00 (50-60 minute session); $125.00 (20-30 minute session); $250.00 (initial session); $50.00/ 15 minutes (Letter/ Report Writing, not billable to insurance, time is rounded up in 15 minute increments)

Clients are responsible for the agreed upon fee for services stated above. They may pay Erin O'Donnell, Psy.D., directly (cash, check, or credit card) at the time of service. Client(s) agree to keep a credit card on file for billing, unless other provisions are made.

Erin O'Donnell, Psy.D., requires **24 hour notice to cancel** an appointment. If notice is given less than 24 hours prior to the appointment, the client is responsible for the full fee as stated above.

Signing the payment agreement indicates that the client and / or his / her parent or legal guardian understand this fee arrangement.

| ____________________________ | ____________________________ |
|---|---|
| Client Signature | Parent / Legal Guardian (if needed) |
| ____________________________ | ____________________________ |
| Printed Name | Printed Name |
| ____________________________ | ____________________________ |
| Date | Date |

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