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: $150.00/ hour

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.

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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