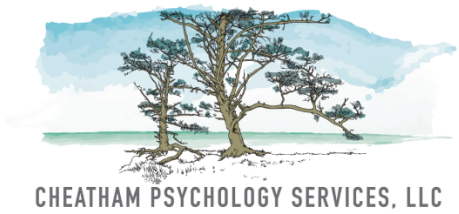

www.cheathampsychology.com

Phone (971) 277-9984/Fax (971) 266-2834

cheathampsychologyservices@gmail.com

FEE AGREEMENT

Patient Name: _____

Payment Plan

I agree that payments or co-pays for services are due at the time of service and the responsibility for payment is mine. Denial of payment by an insurance carrier or other third party does not waive my responsibility to pay.

_____ (Initial Here) I intend to pay in full for the session or co-payment at the time services are rendered with credit/debit/check/cash.

$225 for the evaluation session

$175 for individual therapy

_____ (Initial Here) I understand that phone calls after initiation of treatment that are longer than 5 minutes will be charged the hourly rate, pro-rated in 15 minute increments, which will not be covered by insurance.

Scheduling Policy

_____ (Initial Here) I understand that a no show or cancelled session without 24-hour notice, without attempts to reschedule within the same week, will result in a $50 fee that will not be covered by insurance.

Patient Signature_____ Date_____