

FINANCIAL AGREEMENT

Please notify the Marshall University Psychology Clinic (696-2772) at least 24 hours in advance if an appointment must be canceled. Failure to comply with this policy will result in the clinic billing you the usual fee for the missed individual/group therapy appointment or \$20 for a missed assessment/evaluation appointment.

Two consecutive no shows (failure to cancel and attend two appointments in a row), and/or three consecutive cancellations, will be considered appropriate reason to close your case. This action is necessary because we are a training facility. There is often a waiting list of clients who want to be seen by the student therapists and the students are denied important opportunities to learn and practice whenever their clients miss scheduled appointments. Should your case be closed because of missed appointments, you will be so notified by mail. The notification letter will state that you may contact the clinic if you should need services in the future, but that there is no way to ensure you the same therapist and you will be subject to any delay in scheduling (waiting lists) that any new client would encounter.

(With your therapist, you should complete only one of the statements below and draw a line through the statement not used.)

Psychotherapy

As the party responsible for payment, I agree to pay \$ _____ per 45-50 minute session for the clinical intake, interview, and treatment. I have been provided with a copy of this agreement.

-OR-

Psychological Assessment/Evaluation

As the party responsible for payment, I agree to pay \$ _____ for psychological evaluation, assessment or testing. I have been provided with a copy of this agreement.

-OR-

Group Psychotherapy

As the party responsible for payment, I agree to pay \$ _____ for each session of group psychotherapy. I have been provided with a copy of this agreement.

The clinic operates on a cash basis. Checks should be made out to *Marshall University Psychology Clinic*. Payment is expected at the time services are rendered and usually collected at the end of a therapy session.

I understand and give my permission that if I do not pay all or part of my fee for psychotherapy, a psychological evaluation, and/or group psychotherapy that confidential information necessary to collecting this fee (e.g. such as giving identifying information to a collection agency) can be disclosed in order for this fee to be collected.

Signature

Date

If a representative of the client, describe your authority to act for the client
(e.g. parent, legal guardian, power of attorney, etc.)