Kathryn Kimball, Ph.D.
Evidence-Based Therapy Services

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drkathrynkimball.com ❊ CA License #25628

Agreement to Pay for Professional Services

Payment for services is an important part of any professional relationship. This is particularly the case in therapy; a primary treatment goal is to make relationships and the duties and obligations they involve clear. The payer, often the parent/guardian, is responsible for seeing that the services received are paid in accordance with the terms outlined in this document and in the **Client Information Brochure**.

CPT CODE	SERVICE PROVIDED	MINUTES	FEE
90791	Diagnostic Interview	50—90	$350.00
90832	Individual Psychotherapy	25-30	$200.00
90834	Individual Psychotherapy	45–53	$275.00
90837	Individual Psychotherapy	55-65	$300.00
90846	Family Psychotherapy (w/o client present)	60	$300.00
90847	Family Psychotherapy (with client)	60	$300.00
PHONE	Phone Consultation*	5	$25.00
EMAIL	Email Consultation *	5	$25.00
MISSED	Missed Appointment		**
CANCELLED	Cancelled Appointment (w/out 48 hrs. notice)		**
ISF	Returned Check		$30.00

** Phone and email consultation charges accrue in 5 minute blocks (i.e. $15/5min). Depending on your individualized treatment needs (e.g., family therapy, DBT, skills coaching), clients receive a certain number of complimentary minutes per week. This will be discussed and agreed upon at the outset of treatment. ** Missed/Canceled Session fees depend on type of session planned*

I understand that a credit card may be used for any other outstanding balance on my account. If the credit card is declined, I will be expected to supply another credit card number or pay the full charge by other means. I understand that this is a requirement to be seen for services.

Credit Card Number: _____

Credit Card Type: _____ **Expiration Date:** _____ **CVV:** _____

Name on Card: _____

Billing Address: _____

Phone: _____

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I hereby acknowledge having received and reviewed the information contained in this document and have asked any questions necessary for clarification. I understand that fees are due at the beginning of each session and that I am responsible for all fees, regardless of if I expect these charges to be covered by my insurance company or another third-party payer. I understand that I am responsible for submitting all insurance claims on my own behalf. I understand that I will be charged for missed appointments or appointments canceled with less than 24-hours' notice and that my insurance company will not reimburse me for missed sessions or sessions canceled with insufficient notice. Additionally, I understand that telehealth, as well as phone and email consultation, are not typically covered by insurance or third party payers, and that these services may constitute an out-of-pocket expense for which I am responsible. I understand that there will be a monthly service fee of 1.5% for all outstanding charges (18%/year) and that unpaid balances may be turned over to a collection agency.

_____ _____

Payer's signature **Date**

_____

Printed name