Marie T. Rogers, Ph.D., PA

Licensed Psychologist

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Agreement for Psychotherapy or Psychological Evaluation with an Adult

I, _____, consent to receive the following services /procedures /treatments /assessments:

Psychotherapy / Counseling ___

Testing / Assessment / Evaluation ___

Other _____

This agreement demonstrates my commitment and responsibility to pay Dr. Marie T. Rogers for services rendered, understanding that she is not a Medicare provider and she is not a provider on my insurance (or any insurance) plan. Tasks such as, but are not limited to, obtaining authorization for visits and completing insurance paperwork are not customarily provided by an out-of-network provider.

If I choose to submit her invoices as an out-of-network provider, then I understand it is customary for my insurance plan to require a diagnosis. I agree to pay $275.00 for the initial intake and $55./quarter hour for psychological services thereafter. (For example, for a standard 45-minute session, the fee is $165.00.) The exception to this payment fee/schedule includes psychological evaluation/testing (in which the fee for the entire service has been discussed and agreed upon) or other requested/performed psychological services that do not adhere to the traditional payment structure outlined above. Payment is required at the time services are rendered. I understand that I will be charged for any written correspondence that may be requested, telephone calls lasting more than 5 minutes, and for appointments not canceled within a 24-hour period or no-shows.

I have also been informed of my confidentiality and any limits to confidentiality. HIPAA and the Patriot Act have been explained to me and I was given the opportunity to sign the HIPAA form, which also includes the Patriot Act. Also, it is important for you to know that I share office space with independent mental health professionals and health professionals. We are all independently practicing professionals, who share certain expenses and space. While the members share office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to your information without your specific, written permission.

Psychological Testing/Evaluation

For patients seeking psychological testing/evaluation: The assessment will be conducted by this evaluator, for the purpose(s) of _____.

A report or reports concerning the psychologist's findings will be available at or before 5 weeks after the final feedback session unless an alternate arrangement has been made; i.e., the psychologist is waiting for additional information before finalizing a report or cancellations/missed appointments have occurred. The fee for the evaluation (which includes the assessment, interpretation of results, written report, and feedback session to discuss findings) is $2600. and is to be paid in full at the beginning of testing. This is an addition to the intake/clinical interview fee (discussed earlier) of $275.

My signature below means that I understand and agree with all of the points above.

_____ _____
Signature of Patient Date

I have discussed the issues above with the patient. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent for treatment.

_____
Marie T. Rogers, Ph.D.
Licensed Psychologist PY6312

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