AUBREY
PSYCHOLOGICAL SERVICES

CONFIDENTIAL INFORMATION FORM

Client's Name:_____ M/F:_____ Age:_____ Birthdate:_____

Client's Address:_____ City:_____ Postal Code:_____

Parent (or spouse):_____ Client's Physician:_____

Home Phone:_____ Cell Phone:_____

Date of first appointment:_____

FEE INFORMATION

1. I am paying privately. I understand that private fees are due on the date of service.

   My private fee is **$190** per hour (i.e. 50 mins. counselling, 10 mins. documentation);

2. I am not paying directly. As per written authorization the invoices should be sent to:

   Company: _____ Contact Person: _____ Reference_____

   Note: I agree to pay any fees not covered by the above. I have checked with the above contact person and understand my fees will be covered.

CANCELLED APPOINTMENTS

Missed appointments or late cancellations (those without 24 hour notice; not including weekends), will result in a late cancel fee. For example, if you are scheduled for an appointment on Monday, you must call to cancel by Thursday, the week before your appointment, or you will be charged. Except for unpredictable emergencies, **you will be charged a fee equivalent to half a session ($95) when you have not given 24 hours notice.** Insurance carriers do not pay for missed appointments or late cancellations.

I, _____ have read, or have had read to me, the "Psychological Services Agreement". I have discussed those points that I did not understand, and have had my questions, if any, answered. I agree to act according to the points covered in the agreement, and do seek and consent to take part in psychological services provided. I may revoke this consent at any time.

_____	_____	_____
Client (or parent) Signature	Client (or parent) Signature	Date

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