Dr. Samantha DeCaro, Psy.D.
Licensed Clinical Psychologist

(717) 615-2388
DrSamanthaDeCaro@gmail.com
WEBSITE: Drsamdecaro.com

Financial Agreement

PROFESSIONAL FEES

My hourly fee is $___150.00____. In addition to psychotherapy appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour.

_____ (initial)

Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

_____ (initial)

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $___150.00_____ per hour for preparation and attendance at any legal proceeding.

_____ (initial)

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held. Payment schedules for other professional services will be agreed to when they are requested. I accept cash, check, and MasterCard/American Express/Visa/Discover cards. Payment of any unpaid balance on an account must be received in full before the close of the month. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I will not schedule further therapy sessions. I also have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

_____ (initial)

PLEASE READ CAREFULLY AND SIGN BELOW:

I have read, understand, and agree to comply fully with the above policies. I accept full financial responsibility for all professional services rendered.

_____ Date _____
Signature of Patient/Responsible Party

_____
Printed Name of Patient/Responsible Party