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## FEE CONTRACT FOR PSYCHOLOGICAL TREATMENT OR EVALUATION

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Service:** \_\_\_\_\_ Psychotherapy, 45minute session, \_\_\_\_\_ times per week.  
\_\_\_\_\_ Psychological Evaluation  
\_\_\_\_\_ Other

**Fee:** \$150.00 per session or \$150.00 for evaluation

**Conditions:** Payment is expected at the beginning of each session  
Any changes in the schedule or payments must be made with the knowledge and explicit consent of the undersigned therapist and client  
If payment is not made in the agreed upon fashion, services may be discontinued  
If any outstanding balance exists and good faith payment arrangements are not made within 30 days, the account may be turned over to a collection agency

**Insurance:** This office accepts a variety of insurance payment plans. It is the responsibility of the patient to obtain any and all information required in order to determine benefits or receive prior approvals. If you are choosing to utilize your insurance benefits, this office will assist you in completing the paperwork, which may be required in order to file a claim. Monthly billing statements will be provided at your request. Insurance payments will be made directly to you whenever the policy allows for such arrangements.

**Cancellation:** Payment is expected for all scheduled session of therapy until the psychotherapy relationship is terminated either by the patient or the therapist.

**Notification to the therapist of cancellations is expected at least 24 hours prior to the scheduled session. If notification is not made 24 hours in advance of the scheduled session you will be expected to pay for the session at the next scheduled session.**

**Insurance companies are not billed for services not provided if you have failed to provide the 24 hour notice and are charged for the session. You are responsible for the full payment for that session.**

**I HAVE READ, UNDERSTOOD, AND VOLUNTARILY AGREED TO THE CONDITIONS CONTAINED IN THIS FINANCIAL AGREEMENT. I HAVE RECEIVED A COPY OF THIS AGREEMENT.**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_