Service and Fees Agreement

The following statement is designed to clarify the services delivered by the provider, Malcolm E. Anderson, Ph.D., P.C., the rates assigned for said services, and the expectations of the client/patient and the provider/therapist in this therapeutic agreement. This contract is negotiable and may be changed upon the agreement of the provider/therapist and the client/patient.

Fees for Service

Fees for service are due upon delivery of services by cash, check, major credit card or money order. A receipt will be provided for your records. Accounts will be updated and you will be notified of delinquent payments. For trainings and workshops a check is acceptable at the conclusion of the presentation. The standard fees for services are as follows:

- **Individual sessions**: $200.00 per hourly session.
- **Couples and/or Family sessions (1 therapist)**: $250.00 per hourly session.
- **Couples and/or Family sessions (2 therapists)**: $400.00 per hourly session.
- **Intakes, Consultations and Supervision**: $300.00 per hourly session up to three (3) hours plus administrative/preparation fees.
- **Court Documents, Depositions, and Appearances**: $300.00 per hour of work.
- **Half-day trainings**, workshops and/or presentations: $1,000.00
- **Full-day trainings**, workshops and/or presentations: $3,000.00

A full fee will be charged for invalidated or returned checks. If a check is returned for "insufficient funds," the patient/client will be expected to pay for the session *as well as* any service penalty charged to the therapist's account for the invalidated transaction. I reserve the right to utilize third party collectors to ensure proper payment of outstanding debts at the client's expense.

Appointments

Clients in psychotherapy will make their appointments personally with the therapist either by phone call, text message or email and are expected to be on time for appointments. So as to be courteous to other clients awaiting appointments, a ten-minute grace period will be given before rescheduling is considered. If you are expecting to be more than ten minutes late for your appointment, please call to reschedule. If you do not call and arrive late or miss the session completely, you will be expected to render the full payment for the missed session hour.

If you are unable to make your scheduled appointment you must give notice of cancellation within 24 hours of the scheduled time. If you fail to give notice within this time, you will be expected to render the full payment for the session missed. If appointment failure occurs again (twice), the patient will be expected to provide a current credit card to the therapist prior to continuation of services for payments.

Insurance

At this time the provider does not participate on or with any insurance panels and instead collects full fees for services when delivered. Clients with insurance coverage are expected to make full payment for services when rendered and then seek reimbursement on their own with their third party company. The therapist will provide any necessary documentation for the client to expedite this process including a record of client visits and services, an invoice of payments and account balance, a clinical diagnosis, and a summary of treatment interventions as requested from the insurance company for reimbursement.

Therapist/Provider Responsibilities

The therapist/provider will be expected to be on schedule with his appointments and contracted work assignments. A ten-minute grace period will be allowed to accompany paperwork and scheduling conflicts. In the rare event that the therapist finds it necessary to reschedule an appointment, he will try do so within a 24-hour period by phone. As client emergencies may happen there may be occasion when this early notice plan cannot be executed. If, for some reason, the therapist misses an appointment or fails to notify you of a cancelled appointment you will be refunded for the missed appointment.

I/We have read and understand the above information regarding the services provided by Malcolm E. Anderson, Ph.D., P.C. and agree to the negotiated statement by signing below:

_____ _____

Patient/Client/Representative Name (Please Print) Date

_____

Authorized Signature

_____ _____

Patient/Client/Representative Name (Please Print) Date

_____

Authorized Signature

_____

Witness and/or Corporate Seal