# PACIFIC COAST BEHAVIORAL HEALTH

*A Psychological Corporation*

## MARIE A. KING, PH.D.

*CLINICAL PSYCHOLOGY* *NEUROPSYCHOLOGY*

*PSYCHOANALYSIS*

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## SERVICE AGREEMENT

The type of services available at this office include individual, couples/family outpatient psychotherapy and psychological consultation and assessment. Our appointments will be 45 minutes in length, unless we determine that a different schedule best suits your needs. Sessions cannot be extended in the event of your late arrival. Should 3 consecutive appointments be missed, it is most likely that we will not be able to effectively continue to work together, and further sessions will most likely not be scheduled.

Because your appointment involves reserving a specific time period for you, we ask that you provide us with 24-hour notice if you will be unable to keep your appointment. In the event such notice is not provided, there is a failed appointment fee of $250. This must be paid prior to arranging further appointments.

Payment for sessions is expected at the time of our appointment unless we agree to other arrangements. An interest charge of 1 ½ per month (18% annual percentage rate) will be added to any balance remaining unpaid for 30 days. Accounts that become delinquent will be pursued via collection agency, small claims, or other legal means. If you provide a check that is returned by the bank as not payable, you will be charged a fee of $35.00.

If you have insurance that will help you with the cost of psychotherapy, you may request a receipt for services that you may submit to your insurance. However, you, the patient, are ultimately responsible for payment of services.

Please be advised you have the right to refuse to participate in treatment at any time.

By signing below, you assert that you have read and understand the above information and policies and have been given a copy of the Notice of HIPAA Privacy Practices.

Your statement: I authorize Pacific Coast Behavioral Health to provide outpatient psychotherapy for me. By making this authorization I agree to abide by these policies.

| _____ | _____ | _____ |
|---|---|---|
| Client Name | Client Signature | Date |
| _____ | _____ | _____ |
| Guardian Name | Guardian Signature | Date |

If client is under 18: Relationship to client _____