CENTRAL PSYCHOLOGICAL SERVICES, LLC

Payment Contract for Services

Client Name: _____ Date of Birth: _____

Address:_____

Bill to: _____
Person or entity responsible for payment of account if not the client

Address: _____

Federal Truth in Lending Disclosure Statement for Professional Services

I (we) agree to pay Central Psychological Services, LLC, hereafter referred to as CPS, a rate of $_____ for the 90- minute clinical intake evaluation.

I (we) agree to pay CPS a rate of $_____ for a battery of psychological tests (administered under the supervision of a licensed psychologist), including administration, scoring, and written report.

I (we) agree to pay CPS a rate of $_____ per clinical unit (defined as 45 minutes) for:

- ☐ Feedback on Psychological Testing
- ☐ Individual Psychotherapy or Counseling
- ☐ Marital/Couple Psychotherapy or Counseling
- ☐ Family Psychotherapy or Counseling
- ☐ Other _____

Payment will be made ☐ at the time of service; ☐ weekly; or ☐ monthly, by the ___ of each month for that month's provided or anticipated services .
A fee of $ _____ per clinical unit is charged for missed appointments or cancellations with less than 24 hours' notice. Exceptions can be made for cancellations or missed appointments caused by medical emergencies, severe weather, car accidents, etc.

Financial contracts for clients on sliding fee scales (less than the full amount of clinical unit) are reviewed as needed by the client and/or clinician. An addendum signed by the client and clinician will indicate any changes to the fee structure and supplement this contract. Payments are due at the time of service unless otherwise agreed upon in writing. A 1½% per month (18% Annual Percentage Rate) interest charge may be applied to all accounts that are not paid within 60 days of the billing date. Delinquent accounts may be sent to a collections agency. There will be a $25 charge for checks returned for insufficient funds ("bounced checks"). Your clinician may or may not choose to participate in your health insurance network. Please ask your clinician for more information.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of this Payment Contract for Services.

Person(s) receiving services:_____ Date: _____

Person responsible for account:_____ Date: _____
(*If different from the person receiving services*)

Clinician:_____ Date: _____

6335 S. East St.
Indianapolis, IN 46227
P: (317) 780-1610 F: (317) 280-7277
www.centralpsychservices.com