Misha Gutkin, PhD
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Agreement to Pay for Professional Services

I request that Dr. Misha Gutkin provides professional services to me or to _____, who is my _____, and I agree to pay Dr. Gutkin's fee of $ _____ per session/hour for these services. Fees are due at the beginning of each session.

I agree that this financial relationship with Dr. Misha Gutkin will continue as long as Dr. Gutkin provides services or until I inform him that I wish to end it. I agree to meet with Dr. Gutkin at least once before stopping therapy. I agree to pay for services provided to me (the client or my child) up until the time this professional relationship ends.

I agree that I am responsible for the charges for services provided by Dr. Gutkin to me (the client or my child), although other persons or insurance companies may make payments on my (the client's or my child's) account.

Telephone consultations: I understand that telephone consultations may be suitable or even needed when Dr. Gutkin provides services to me (the client or my child). If that occurs, I agree to pay the regular per hour fee stated above, prorated over the time needed for any telephone call exceeding 10 minutes. If Dr. Gutkin needs to have telephone conferences with other professionals as part of my (the client's or my child's) treatment, I agree to pay for these services at the same rate as for regular therapy services.

Late/Cancelled Appointments: *If you are late, we will probably be unable to meet for the full time, because it is likely that I will have another appointment after yours. A cancelled appointment delays our work. I will consider our meetings very important and ask you to do the same. Please try not to miss sessions if you can possibly help it. Your session time is reserved for you. I am rarely able to fill a cancelled session unless I have an advance notice. Your insurance will not cover this charge.*

I (the client/parent of a client/guardian) know that I must call to cancel an appointment at least 72 hours (3 days) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment the rate indicated above. I authorize Dr. Gutkin to keep the following credit card on file and to charge the full session fee if I cancel my appointment in less than 72 hours or fail to come in for my appointment or fail to bring a payment to the appointment.

Card type _____, card #_____, expiration date _____, cvv code _____
Billing Address _____ Fee to be charged $_____ per session/hour.

I authorize Dr. Gutkin to make these charges without additional warning or discussion.

_____ _____ _____
Cardholder Name Cardholder Signature Date

Unpaid balance: I agree that if I have trouble paying my bills on time, I will discuss this with Dr. Gutkin. If the balance on my (the client's or my child's) account remains unpaid for over 30 days, Dr. Gutkin will stop providing services to me (the client or my child). Fees that left unpaid after 60 days will be turned over to small-claims court or a collection service. A late fee of 10% of the unpaid balance over 60 days will be charged each month.

I have read this agreement and agree to act according to everything stated above, as shown by my signature below.

_____ _____
Signature of client (or person acting for client) Date

_____
Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of therapist Date