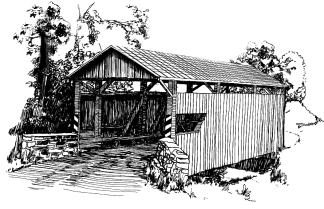


Craig L. Abrams, Ph.D.
Psychologist



1001 W. Glen Oaks Lane, #206
Mequon, WI 53092

414.628.4848

Start the journey

Treatment Agreement

Clinical Fees

The initial assessment session is billed at \$240. Subsequent sessions are billed at \$200. Sessions are 50 minutes long. I am responsible for verifying my benefits and determining whether any pre-authorization is needed.

Balances remaining over 120 days from the date of service (whether billed to me or to my insurance company) incur monthly interest charges of 18% unless Craig Abrams has agreed, in writing, to special payment arrangements. I will pay all balances (including all interest charges) that remain unpaid by my insurance company after 120 days from the date of service.

I must pay all costs of collection, including reasonable attorney's fees and costs, in the event any invoice requires collection efforts. All accounts referred to a collection agency shall be subject to an additional fee of \$50.00, which is my responsibility to pay in full.

Missed Appointments

24 hours notice is required to cancel an appointment. Failure to provide such notice will result in full charges being billed directly to me for the missed session.

Please initial: _____ I will self-pay and am financially responsible for all charges incurred.

Consent for treatment

I have read the above information, and I understand the counseling services to be provided. I have had the opportunity to receive acceptable and understandable answers to my questions. I understand that this consent is valid for one year and may be withdrawn in writing at any time. I understand that if I wish to file a grievance, I may request a copy of the grievance procedure. I have received a copy of the *Client Bill of Rights* and the *Notice of Privacy Practices*. I am availing myself of this service voluntarily and with knowledge of its benefits, risks, and limitations.

Client's signature _____

Date _____

Therapist signature _____

Date _____