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EVALUATION SERVICES - CONTRACT

Name of Patient: _____Birthdate: _____

This document authorizes Christina Remek, Psy.D., P.A. to provide evaluation services to me and/or my child. These services may include clinical interviews and testing sessions at a rate of $180.00 per hour or at a flat fee of $_____ as agreed upon by both parties. Appointments will be at a time and place, and with a frequency, agreed upon by both parties.

Additional services over 15 minutes in length (e.g. phone conversations, letter writing, teacher and physician consultations, reviews of records, etc.) may be billed at the same hourly rate unless otherwise agreed upon. (Such additional services will not be delivered without the verbal agreement of both parties.)

I understand that all services will be subject to the parameters described in the "***Clinical Services - Policies and Procedures***" document and I have received a copy of this document and understand these policies.

_____ _____
Signature of Patient/ Personal Representative Date

_____ _____
Printed Name Personal Representatives Authority
(As appropriate - e.g. Parent)

_____ _____
Signature of Provider Date