Christina A Remek, Psy.D., P.A.
6919 SW 18th Street, Suite 201, Boca Raton, FL 33433
Ph: (561) 206-4601
Email: caremek@gmail.com
Website: www.drremekpsyd.com

PSYCHOTHERAPY SERVICES - CONTRACT

Name of Patient: _____Birthdate: _____

This document authorizes Christina A. Remek, Psy.D., to provide psychotherapeutic services to me and/or my child. These services may include individual therapy, biofeedback, and/or parent collateral sessions at a rate of _____ per 50-minute "hour". 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