# Grelling Psychology Associates

*sensitive, professional care for individuals and families*

925-215-8694 Phone
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www.drgrelling.com


## PSYCHOTHERAPY SERVICES - CONTRACT

Name of Client: _____Birthdate: _____

This document authorizes _____ (therapist name) to provide psychotherapeutic services to me and/or my child. These services may include individual therapy, family therapy, 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.) In addition, sessions cancelled with less than 24 hours notice will be billed at the full rate.

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

In the event of an emergency, my therapist has permission to contact the following trusted person:

Name _____

Phone Number _____

Email address _____

_____ _____
Signature of Client/ Personal Representative Date

_____ _____
Printed Name Personal Representatives Authority
(e.g. parent, guardian, self)

_____ _____
Signature of Provider Date

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