Bonnie L. Atkinson, Ph.D., L.L.C.
444 N. CEDAR STREET
FLORENCE, ALABAMA 35630

Licensed Psychologist (256) 767-6139

CONSENT TO TREATMENT

- I consent to Psychological Treatment with Dr. Bonnie L. Atkinson
- I understand that in any family or couple therapy, each individual is entitled to confidentiality and no one has the right to waive that right for the other person.
- I understand that the **full charge** will be made for the time reserved for an appointment unless a **24 hour notice is given**.
- I understand that 24 hour coverage is not guaranteed. **If Dr. Atkinson is out of town, or cannot be reached for an emergency, the patient should go to the Emergency Room of the local hospital.**

Signed: _____ Date: _____

Witness: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FORM

AUTHORIZATION TO RELEASE INFORMATION: In the event of filing insurance or any third party claim for the above client, I hereby authorize Bonnie L. Atkinson, Ph.D., L.L.C., to release any medical and/or psychotherapy information necessary to process the claim to my insurance carrier or third party payer. A copy of this authorization is valid as the original.

* We file insurance as a courtesy to our patients. We do not hold the insurance company responsible for your bill.
* I understand that the charges made for professional services may not be covered in full by the insurance, even though insurance may be filed. Thus, if a deductible and co-payment is required, it will be paid at the time of service as mandated by the insurance company.

Signed: _____ Date: _____

Authorization to pay benefits to Bonnie L. Atkinson, Ph.D., L.L.C.
I authorize payment directly to Bonnie L. Atkinson, Ph.D., L.L.C. for Mental Health Services rendered to me or my dependent.

Signed: _____ Date: _____

CONTINUED, PLEASE SEE NEXT PAGE

Bonnie L. Atkinson, Ph.D., L.L.C., has the following policies concerning fees and payment responsibilities:

1. Bonnie L. Atkinson, Ph.D., L.L.C. has the following established fees* for basic service:

Intake Evaluation	$155.00	50 minutes
Individual Psychotherapy	$125.00	50 minutes
Family Psychotherapy	$125.00	50 minutes
Diagnostic Testing	Per Test	
Research/Phone Consults	$125.00	50 minutes or part thereof

2. I also acknowledge full responsibility for the payment of such services, and agree to pay for them at the time of service.
3. Appointments are scheduled for 50 minutes. **Cancellations are required 24 hours in advance or the full fee will be charged.**
4. I understand that the patient or responsible party is solely responsible for the payment of all services. If the account becomes delinquent in payment, I agree to pay all costs of collection, including reasonable attorney fees.
5. I understand that if my account is placed ion the hands of an attorney or collection agency, the general rules of confidentiality and privilege are waived.
6. I understand that any charges that might occur if my check is returned will be my responsibility to pay. A minimum of $30.00 will be charged.

Other information or comments including payment agreement details:

_____

_____

_____

I agree to be responsible for the payment of all services rendered to the above named client. In failing to do so, I hereby waive all claims or rights of exemption and agree to any reasonable attorney's fee for the collection of the account if assigned to a collection agency for collection.

Signed: _____ Date: _____

Witness: _____

*fees will be reviewed periodically and are subject to change.