Sarit Lesser, Psy.D
Clinical Psychologist

154 Waterman st. Suite 10a
Providence, RI 02906

Agreement to Pay for Professional Services

I request that the clinician named below provide professional services to me and I agree to pay this clinician's fee of $ per session for these services or the fee of $____ for _____.

I understand and agree that I am responsible to pay the charges for services provided by this clinician to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

I agree to pay for services provided to me (or this client) up until the time we end the relationship. We will discuss ending, and a date will be agreed to and recorded in this client's medical records; or I will inform the clinician, in person or by certified mail, that I wish to end it. I agree to meet with this clinician at least once before stopping therapy.

I have also read this clinician's "Information for Clients" or practice brochure and agree to act according to everything stated there, as shown by my signature below and on the brochure.

_____ ____/____/____

Signature of client (or person acting for client) Date

_____

Printed name of client (or person acting for client)

I, the clinician, have discussed the issues above with the client (and/or the person legally acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent and able to give informed and willing consent.

_____ ____/____/____

Signature of clinician Date

❑ Copy accepted by client or ❑ Copy kept by clinician