Wellspring Psychological Services Phone: 650-429-8828

Caroline C. Fleck, PhD
Licensed Psychologist
451 N. Shoreline Blvd, Suite 1, Mountain View, CA 94043
drfleck@wellspringpsychologicalservices.com

Agreement to Pay for Professional Services

Payment for services is an important part of any professional relationship. You are responsible for seeing that the services received are paid in accordance with the terms outlined in this document and in the Client Information and Consent to Treatment form.

CPT/OFFICE CODE	SERVICE PROVIDED	MINUTES	FEE
90791	Diagnostic Interview	60-90	$350.00
90832	Individual Psychotherapy	25	$110.00
90834	Individual Psychotherapy	50	$225.00
90837	Individual Psychotherapy	75-90	$300.00
90846	Family Psychotherapy (w/o client present), 50 minutes	50	$225.00
90847	Family Psychotherapy (with client present), 50 minutes	50	$225.00
90846	Family Psychotherapy (w/o client present)	75-90	$300.00
90847	Family Psychotherapy (with client present)	75-90	$300.00
90839	Psychotherapy for Crisis	60	$275.00
90840	Psychotherapy for Crisis (add on to 90839)	30	$137.00
98966, 98967, 98968	*Phone consultation	0-30	$15.00/5 mins
98969	*Email/secure text messaging consultation	5	$15.00/5 mins
90899	Letter writing, treatment summary preparation, etc. (fees are prorated in 5-minute increments)	60	$100.00
MISSED	Missed Appointment (charges accrue for time scheduled)		
CANCELED	Cancelled Appointments w/o 24-hrs Notice (charges accrue for time scheduled)		
ISF	Returned Check		$30.00
GT	Modifier used to reflect sessions conducted via video conferencing. There is no additional fee for these sessions.		

***Phone and email consultation charges accrue in 5-minute blocks (i.e. $15/5min). Clients receive 5 complimentary minutes each week. Phone and email consultation beyond the complimentary 5 minutes are charged according to the stated rates. Complimentary minutes do not rollover.**

You may provide your credit card information via this secure form, or in person at your first session.

Credit Card Number: ______________________________

Credit Card Type: __________ Expiration Date: __________ CVV: __________

Name on Card: ______________________________

Billing Address: ______________________________

Phone: ____________________

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In signing this document, you are stating: "I acknowledge having received and reviewed the information contained in this agreement and have asked any questions necessary for clarification. I understand that fees are due at the beginning of each session and that I am responsible for all fees, regardless of if I expect these charges to be covered by my insurance company or another third-party payer. I understand that I am responsible for submitting all insurance claims on my own behalf. I understand that I will be charged for missed appointments or appointments canceled with less than 24-hours' notice and that my insurance company will not reimburse me for missed sessions or sessions canceled with insufficient notice. I understand that there will be a monthly service fee of 1.5% for all outstanding charges (18%/year) and that unpaid balances may be turned over to a collection agency. I understand that a credit card may be used for any other outstanding balance on my account. If the credit card is declined, I will be expected to supply another credit card number or pay the full charge by other means. Finally, I understand that phone and email consultation are not typically covered by insurance or third-party payers, and that these services may constitute an out-of-pocket expense for which I am responsible."

________________________________ ________________________________

Signature Date

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Printed name