Jeffrey B. Gillman, Ph.D.
Licensed Clinical Psychologist
Pediatric, Adolescent, and Adult Psychology
2950 Northup Way, Suite #204
Bellevue, WA 98004

Agreement to Pay for Professional Services

I request that Jeffrey Gillman, Ph.D., provide professional psychological services to me or to _____ who is my/our _____, and I/we agree to pay the fee of **$140.00 per session** for psychotherapy or consultation services, and **$200.00 per hour** for psychological assessment (e.g., "testing") services.

I agree that this professional relationship and financial agreement with Dr. Gillman will continue as long as he provides service, or until I inform him, either in person or by certified mail, that I wish to end this professional relationship. I agree to meet with Dr. Gillman at least once before stopping psychotherapy services, in order to reach a mutual understanding of the basis for termination and to ensure appropriate psychotherapeutic closure. I understand that I/we will remain responsible for payment of the balance of fees accrued up to and including the final session, and agree to pay for all professional services provided to me/my child/my family.

I/we understand that while other persons or third party payers (e.g., insurance companies) may make payments on my/my child's/my family's account, I/we also understand and agree that I am/we are ultimately responsible for the charges incurred for the professional psychological services provided by Dr. Gillman to me/my child/my family.

I understand that if I/we do not cancel scheduled appointments with at least **48-Business-hours notice** (e.g., at least **2 full business days**; weekends and holidays are excluded), Dr. Gillman reserves the right to bill me/us for this scheduled appointment time, at the above rate.

I have also read Dr. Gillman's Patients Rights and Disclosure of Information Brochure and voluntarily agree to participate in accordance with the policies stated therein, as shown by my/our signature(s) below.

_____	_____	_____
Signature of Patient	Printed Name	Date
_____	_____	_____
Signature of Parent/Legal Guardian	Printed Name	Date
_____	_____	_____
Signature of Parent/Legal Guardian	Printed Name	Date

I, Jeffrey Gillman, Ph.D., have discussed the issues above, including the policies described in the Patient Rights Brochure, with this patient (or the parent/guardian acting on behalf of this patient). My observations of this person's behavior and responses give me no reason to believe this person is not fully competent to give informed consent to enter into this agreement.

_____	_____
Signature	Date