CLOCKTOWER
PSYCHOLOGICAL ASSOCIATES, LTD

Professional Service Agreement

Dear Client:

We appreciate and welcome the opportunity to be of service and have prepared this letter to outline our policies with regard to the services we offer. As a client you agree to the following:

If for any reason you choose to cancel your appointment, we require at least 24 hours advance notice of the cancellation. If timely notice is not given, our services may be charged to you at our agreed rate. Please note that our services may be terminated at our option due to appointment cancellations.

Clinical services will be charged to you based upon the following Fee Schedule. Telephone conferences for clinical services may be invoiced at the appropriate regular fee.

Fee Schedule:

Diagnostic Interview	45-50 minutes	$210
Psychotherapy	16-37 minutes	$90
Psychotherapy	38-52 minutes	$135
Psychotherapy	53-60 minutes	$165
Family Psychotherapy	45-50 minutes	$155
Interactive Complexity	add on	$25
Neuro/Psychological Testing	variable	variable
Court Record Review / Deposition	variable	$250 / per hour

We reserve the right to change, modify or alter any of the terms of this Agreement in the future, upon first giving notice to you. Any objection to such changes, modifications, or alterations, must be made promptly upon receipt of the notice. If no objections are made, it will be assumed you have accepted the changes, modifications or alterations made.

____
Patient Name

Your signature below indicates that you have read and fully understand the provisions set forth above.

______________________________ ____/____/____
Patient Signature **Date**

______________________________ ____/____/____
Signature of Personal Representative **Date**

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided;

_____ Parent
_____ Guardian

Other: ______________________________

~ 847.726.2400 ~

1 Golfview Road • Suite 1 • Lake Zurich, IL 60047