Jeanne M. Morris-Foley, N.P. Psychiatry P.C
4655 Nesconset Highway
Port Jefferson Station, N.Y. 11776

FEE AGREEMENT

Name of Client: _____

Name of Therapist: _____

The following fee(s) is established for the following service(s):

Individual/Couple Treatment/Medication $ _____

Group Therapy $ _____

As part of my responsibility as a client receiving counseling services with Jeanne Morris-Foley, I clearly understand that:

1. Payment for services is expected at the time of each visit.

2. Because I have contracted for a professional service, I am responsible for the established fee for all reserved appointments and therefore, I must pay for failed, and cancelled appointment with the exception of medical emergency or pre-planned vacation as per Jeanne Morris-Foley policies.

3. I will immediately inform my therapist if I become eligible for insurance benefits or if my insurance benefits change.

4. I authorize "assignment" of insurance-benefits to Jeanne Morris-Foley as partial or full payment for services rendered. If my insurance company does not "assign" benefits, I will sign over all such benefit checks to Jeanne Morris-Foley as soon as I receive them.

5. I will immediately notify my couonselor of any change in personal or family income-such as an increase in salary; second job/loss of job, or other family member working.

6. If I have any past due fees, I will pay these prior to my termination of treatment.

_____ _____

Client Signature Theratpist Signature

_____

Date