insight
PSYCHOLOGICAL SERVICES
Arvind Karwan, Ph.D., Licensed Psychologist – 343 W. Drake Rd. Suite 200, Fort Collins, CO 80526
(970)631-5400 – arvind@insightpsychologicalservices.org

PAYMENT AGREEMENT

Client Full Name: _____

Date of Birth:_____/_____/_____ Social Security #:_____

Full name of person responsible for payment of services (if different from client listed above):

_____

Date of Birth:_____/_____/_____ Social Security #:_____

I, _____, request that Dr. Arvind Karwan of Insight Psychological Services, LLC, provide professional services to the client listed above (hereafter referred to as "Client"), and I agree to pay Dr. Karwan's fees for these services. Although other persons or insurance companies may make payments on my/Client's account, I agree that I am ultimately responsible for the charges for services provided by Dr. Karwan to me/Client.

I agree that I and/or Client will inform Dr. Karwan as soon as possible, and no less than 24 hours prior to the start of a scheduled session, if I need to cancel or reschedule a session for any reason. I agree to pay up to the full session fee for any scheduled session that is missed without at least 24 hours prior notice. I understand to communicate with Dr. Karwan directly if I am seeking any exceptions to this policy for unforeseen circumstances out of my/Client's control (e.g., accident, sudden illness), and that exceptions will be made on a case-by-case basis and at the sole discretion of Dr. Karwan.

I agree that this financial relationship with Dr. Karwan will continue as long as Dr. Karwan provides services or until I inform him (in person, by phone, or by certified mail) that I wish to end the professional services. I understand that it is highly advised that I/Client meet with Dr. Karwan for at least one additional session before stopping therapy to properly terminate treatment. I agree to pay for services provided to me/Client up until the time the relationship is ended.

I understand that I am required to pay the balance on my/Client's account in a timely manner. I understand that Dr. Karwan may turn over any charges that are more than 90 days past due to a collections agency, unless I contact Dr. Karwan directly (in person, by phone, or by certified mail) to make alternative payment arrangements and Dr. Karwan has given me expressed written agreement of this arrangement.

By signing below, I am stating that I have read over the preceding information, that it has also been provided to me verbally, and that I fully understand and agree to all of the terms listed above as my responsibilities for payment of services by Dr. Karwan.

_____ _____

Signature of Person Responsible for Payment Date