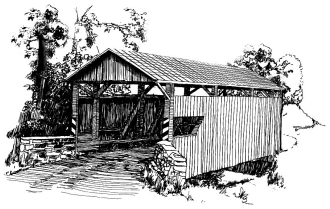
Craig L. Abrams, Ph.D.
Psychologist
414.628.4848



Start the journey

1001 W. Glen Oaks Lane, #206
Mequon, WI 53092

Treatment Agreement

Clinic Fees
The initial assessment session is billed at $220. Subsequent sessions are billed at $180. Sessions are 50 minutes long. I am responsible for verifying my benefits and determining whether any pre-authorization is needed.

Balances remaining over 120 days from the date of service (whether billed to me or to my insurance company) may incur monthly interest charges of 18% unless Craig Abrams has agreed, in writing, to special payment arrangements. I will pay all balances (including all interest charges) that remain unpaid by my insurance company after 120 days from the date of service.

Missed Appointments
24 hours notice is required to cancel an appointment. Failure to provide such notice will result is full charges being billed directly to me for the missed session.

Please initial one: _____ Bill my insurance. _____ I will self-pay.

Assignment of benefits
I hereby authorize release to my insurance company and/or associated professionals any information from my records which may be necessary to substantiate the request for payment of services. I authorize payment for the benefits otherwise payable to me in the amount which covers but does not exceed services delivered**. I understand that although my health insurance will be billed, I am financially responsible for all charges incurred.**

Consent for treatment
I have read the above information, and I understand the counseling services to be provided. I have had the opportunity to receive acceptable and understandable answers to my questions. I understand that this consent is valid for one year and may be withdrawn in writing at any time. I understand that if I wish to file a grievance, I may request a copy of the grievance procedure. I have received a copy of the *Client Bill of Rights* and the *Notice of Privacy Practices*. I am availing myself of this service voluntarily and with knowledge of its benefits, risks, and limitations.

Clients signature_____ Date _____

Therapist signature_____ Date_____