Gloria H. Ireland, M.Ed., E.A.C., Psychologist

16600 West Sprague Road, Suite 255, Cleveland, Ohio 44130. Cleveland (440) 891-8848.
3200 West Market Street, Suite 101, Fairlawn, Ohio 44333. Akron (330) 606-7449.

PAYMENT AGREEMENT CONTRACT

I, _____*(Client or Responsible Party)*, promise to pay Gloria H. Ireland *(Provider),* FOR SERVICES RENDERED TO _____(name of Client). This payment will consist of consecutive weekly / monthly payments of $_____each, and will continue until the balance due is paid-in-full. The first payment is due by the next time of service.

Services

_____First Session Evaluation	……	$_____
_____Therapy Sessions / Phone Consultations	45 Minutes	$_____
_____Extended Therapy Session / Phone Consult.	60+ Minutes	$_____
_____Marital or Family Therapy	45-50 Minutes	$_____
_____Extended Marital or Family Therapy	60+ Minutes	$_____
_____Group Therapy (Specialty Groups)	45 Minutes	$_____
_____Extended Group Therapy (Specialty Groups)	60+ Minutes	$_____
_____Preparation of Report (per 15 Min.)	_____Minutes	$_____
_____Court Preparation / Presentation (per 15 Min.)	_____Minutes	$_____
(Including responding to subpoenas or attending depositions)		(Plus associated legal fees)
_____ _____	_____Minutes	$_____

If you are using insurance, you are responsible to know your in-network and out-of-network benefits. If I am an "in-network" provider, you will be responsible for any unmet deductible and co-payments. If I am not an "in-network" for your insurance, you are responsible for any differences between what your insurance pays, and my fees as listed above if the insurance pays me directly, otherwise you are responsible for the entire amount and can collect from the insurance company what it pays you. If you are not using insurance, payment in full is expected at the time of service, and can be made by cash or personal check. **Missed appointments that are not cancelled with a 24 hour notice will be charged a $50.00 fee, which should be paid at the next scheduled appointment, or be received within 1 week by mail.** Insurance will not reimburse for missed appointment charges.

If you fail to pay as agreed, you agree that I have the option of using legal means to secure this payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary you agree to pay any costs associated with collection, including legal fees. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature and dates of services provided, and the amount due. You agree that I may do that.

Your signature below indicates that you have read the information in this document and have had an opportunity to ask any questions about it that you may have. By signing below you are stating that you accept and agree to abide by the terms set forth in this Contract, including to make payments as set forth in this Contract.

_____

Client's or Responsible Party's Printed Name

_____

Address

_____

Phone Number

_____ _____

Signature Date