DAVID M. STROUP, PH.D.
1037 NE 65th Street #345 Seattle, WA 98115
206.395.9301 david@davidstroupphd.com

PAYMENT AGREEMENT

I request that David M. Stroup, Ph.D., provide professional psychological services to me or to _____ who is my/our _____.

I / we agree to pay the fee of $260.00 for an initial diagnostic interview session, $170.00 per hour for psychotherapy or consultation services, $225.00 per hour for conjoint (couple / family) sessions, and $190.00 per hour for psychological assessment (e.g., "testing") services.

I agree that this professional relationship and financial agreement with Dr. Stroup will continue as long as he provides service, or until I inform him, either in person or by certified mail, that I wish to end this professional relationship. I agree to meet with Dr. Stroup at least once before stopping psychotherapy services, in order to reach a mutual understanding of the basis for termination and to ensure appropriate psychotherapeutic closure. I understand that I/we will remain responsible for payment of the balance of fees accrued up to and including the final session, and agree to pay for all professional services provided to me/my child/my family.

I/we understand that while other persons or third party payers (e.g., insurance companies) may make payments on my/my child's/my family's account, I/we also understand and agree that I am/we are ultimately responsible for the charges incurred for the professional psychological services provided by Dr. Stroup to me/my child/my family.

I understand that if I/we do not cancel scheduled appointments with at least 24-Business-hours notice (e.g., at least 1 full business day; weekends and holidays are excluded). Dr. Stroup reserves the right to bill me/us for this scheduled appointment time, at the above rates.

_____ _____
Signature of Patient Date

_____
Printed Name

_____ _____
Signature of 2nd Patient (if appropriate) Date

_____
Printed Name

_____ _____
Signature of Parent/Legal Guardian Date

_____
Printed Name

_____ _____
Signature of Parent/Legal Guardian Date

_____
Printed Name

I, David M. Stroup, Ph.D., have discussed the issues above with this patient (or the parent/guardian acting on behalf of this patient). My observations of this person's behavior and responses give me no reason to believe this person is not fully competent to give informed consent to enter into this agreement.

_____ _____
Signature Date