Judi Oshinsky Psychotherapy LLC
Judith Cohen Oshinsky, M.S.S.W., L.C.S.W.
Psychoanalytic Psychotherapy

85 Raritan Ave., Suite 500-C
Highland Park, NJ 08904

Phone: 732-777-1500
Fax: 732-210-0221

Agreement to Pay for Professional Services

I request that Judith Cohen Oshinsky, LCSW provide psychotherapy services to me or to _____, who is my _____ , and I agree to pay this therapist's fee of $ _____ per session for these services. I understand that this is a discounted fee negotiated through the insurance company. I understand that I am financially responsible for the fee if the insurance company does not pay. I also understand that my therapist reserves the right to re-negotiate the fee if my therapy sessions are no longer covered by this insurance. I understand that I am responsible for payment for phone contacts, written correspondence/reports, photocopying and other administrative tasks that are not reimbursable by insurance.

I agree that this financial relationship with this therapist will continue as long as the therapist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

I understand that continuity is important to the positive outcome of my therapy. I also understand that the therapist reserves my session time on a regular basis and this time cannot be filled by anyone other than me. Thus I understand that I am financially responsible for any scheduled sessions that cannot be rescheduled within the same week with the exception of planned vacations that are discussed with my therapist in advance.

I understand that therapist will exercise the right to use a collection agency or small claims court if my account is delinquent and that I am responsible for any related charges. I understand that therapist will suspend psychotherapy services for accounts more than 3 sessions in arrears. I also understand that I am responsible for the bank fee for any returned checks.

_____
Signature of client (or person acting for client) Date

_____
Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____
Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist