Tom Cicciarelli, Psy.D. - PSY17298
350 Parnassus Avenue – Suite 601 A
San Francisco, CA 94117
415-767-5199

Fee Agreement Form

Please check any of the following that apply to your situation:

☐ I do not currently have insurance coverage for psychotherapy services:

☐ I have insurance coverage for psychotherapy, but I choose not to use it. I understand that by doing so I am waiving any right to reimbursement from my insurance company for services provided.

☐ I have insurance coverage, but I understand that Dr. Cicciarelli's services are not covered by my plan.

_____

I agree to pay the agreed upon fee of $_____ per session. I understand that this fee must be paid by check or cash and that it is due at the time of each session.

I also understand that I may be responsible to pay the fee indicated above for any missed or cancelled sessions unless I provide Dr. Cicciarelli 24 hours advanced notice of cancellation.

By signing below, I am indicating my full agreement with the above statements and attesting that the information provided above is true and accurate.

Patient (or Responsible Party) Name:_____

Patient (or Responsible Party Signature:_____

Date Signed: _____ /_____ /_____

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