LaGrange Behavioral Health, LLC
115 North College Avenue, Suite 220, Bloomington, IN 47404
Phone: (812) 340-6993 | Email: drsarahlagrange@gmail.com

Financial Agreement

I request that Sarah J. LaGrange, Ph.D., HSPP, provide professional psychological services to me, _____ or to _____, who is my _____.

I agree to pay this provider's fee of $____per intake and $ _____ per session for these services.

I agree that this financial relationship with LaGrange Behavioral Health(LBH) will continue as long as I am receiving services or until I inform LBH, in person or by certified mail, that I wish to stop services. I agree to meet with my LBH provider at least once before stopping treatment.

I know that I must cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for the appointment. I understand that if payment for the services I receive is not made, the provider may stop my treatment and refer me elsewhere. I agree that I am responsible for the charges for services provided by LBH to me (or this client), although other persons or insurance companies may make payments on my account. I have also read the LBH "General Information for Clients" statement, including the "Professional Fees" statement which outlines charges beyond the standard appointment.

I agree to act according to everything stated above, as shown by my signature below and on the Authorization for Treatment form.

_____ _____

Signature of client (Parent/Legal Guardian) Date

_____

Printed name

I, the psychologist, have discussed the issues above with the client (and/or parent/legal guardian). 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 psychologist Date

_____

Printed name

This is a strictly confidential medical record. Redisclosure or transfer is expressly prohibited by law.