19910 Malvern Rd
Suite 212
Shaker Heights, OH 44122
Phone: 216-438-1905

Rita Bryce, JD, LISW

Child, Adolescent and Adult Therapist

Service Agreement

Name of Client:					Date of Birth:
Address:					
Home #:	Ok to leave a message		Yes		No
Work #:	Ok to leave a message		Yes		No
Cell #:	Ok to leave a message		Yes		No
Email:					
Occupation and Employer:					
Who referred you to my practice?					
Responsible Party Name and Relationship (Parent/Guardian/Spouse/Partner):					
Responsible Party Address and Phone Number(s):					
Responsible Party Place of Employment:					
Emergency Contact Name and Phone Number(s)					

Payment and Health Insurance

PLEASE READ CAREFULLY. I accept Medical Mutual insurance. If you do not have Medical Mutual, you may file claims with your insurance company to reimburse you for payments you make for my services. If you are relying on your health insurance to cover or defray the cost of services, check your policy's provision for out-of-network providers.

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Professional Services Agreement	
Below is a list of my fees. Please read carefully and sign to acknowledge your understanding and acceptance of these terms. **Initial Consultation/Assessment: $175** **Office visit (50 minutes): $125** **Extended sessions and phone consultations are billed pro rata.** **There is no charge for the initial 15 minute phone consultation.**	
Cancellation Notice	
Twenty- four hours cancellation notice is required. Should you cancel with less than a twenty-four hour notice, you will be billed a fee for the time reserved unless the time is filled by another client.	
Disclosure	
Client understands that Rita Bryce will not agree to testify or otherwise agree to involvement in client legal issues.	
I have read and understand all of the above. I accept full financial responsibility for all fees incurred.	
Client name (please print):	
Client Signature:	**Date:**
Responsible Party Relationship and Signature, if parent or guardian:	**Date:**

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Notice of Privacy Practices	
Please sign below to indicate that you have read the Notice of Privacy Practices, which is available for download on my website. You may also request a hard copy.	
Client name (please print):	
Client Signature:	**Date:**
Responsible Party Relationship and Signature:	**Date:**

I will assume I can leave a voicemail and send information to your address unless you request alternative handling of confidential information. If you are opting for alternative handling of your confidential information, give specific instructions on how you want to be contacted and provided information. Email and texting should only be used to set appointment dates and times.

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