Christine Wilkes, Psy.D.

Licensed Psychologist

2100 NE Broadway Street, Suite 331

Portland, OR 97232

503-888-0591

FEE AGREEMENT

CLIENT NAME:

_____ _____

Last First Middle Initial Date of birth

FINANCIAL RESPONSIBILITY (Please list name and address of the person financially responsible)

Name: _____ Phone #: _____ Relation to client: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of birth: _____

INSURANCE INFORMATION

Primary Insurance: _____ Identification Number: _____

Group Number: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder's date of birth: _____

First Name Middle Initial Last name

Policy Holder's Address: _____

Customer Service Phone Number on Insurance Card: _____

FOR SECONDARY INSURANCE ONLY:

Secondary Insurance: _____ Identification Number: _____

Group Number: _____ Employer: _____

Policy Holder's Name: _____ Policy Holder's date of birth: _____

Policy Holder's Address: _____

Customer Service Phone Number on Insurance Card: _____

PLEASE REVIEW FEE AGREEMENT CAREFULLY: I understand that payment is due in full at the beginning of the evaluation process. I understand that my insurance may not pay for Dr. Wilkes' services and I agree to pay for the services, regardless of what insurance pays. I authorize the release of any information necessary to process the claim with my insurance. I agree to notify Dr. Wilkes of any changes in my insurance coverage.

_____ _____

Signature of Responsible Party Date Witness Date