

Philip Burke, PhD

Licensed Clinical Psychologist

West County Medical Center
19 East Shawnee Drive
Murphysboro, IL 62966
(618) 684-8700

Agreement to Pay for Professional Services

I request that Philip Burke, PhD, provide professional services to me (or to _____, who is my _____), and I agree to pay this psychologist's fees as listed in his current fee schedule as of the date of this agreement.

I agree that this financial relationship with this psychologist will continue as long as the psychologist provides services or until I inform him or her, in person or by certified mail, that I wish to end it. 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 psychologist to me (or this client), although other persons or insurance companies may make payments on the account.

I have also read this psychologist's *Information for Clients* brochure and agree to act according to everything stated there, as shown by my signature below.

Signature of client or other responsible party

Date

Printed Name

Release and Assignment of Benefits

I give this office permission to release any information obtained during examinations or treatment of this client that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself.

Assignment of benefits: I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to Philip Burke, PhD. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

Client's signature (or legal guardian)

Date

Printed Name

Insured's signature (if different from client)

Date

Printed Name

WITNESS:

I, the below named individual, witnessed those individuals signing this agreement. To the best of my knowledge, they were fully competent to give informed and willing consent to the above.

Witness signature

Date

Printed Name

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