KATHLEEN RAPP, LCSW

FEE AGREEMENT

By signing below, I am indicating that I have read the document *How We Will Work Together and Financial Policies*. I have discussed this document with Kathleen Rapp and have had the opportunity to ask any questions I have had. My questions have been answered to my satisfaction. I understand and agree to meet my financial responsibilities in receiving treatment and services in this practice setting.

I agree to:

_____ remit to Kathleen Rapp, LCSW a fee of $_____.

_____ remit a co payment in the amount of $_____ in keeping with the policies of my health benefits.

_____ the assignment of my health insurance benefit to Kathleen Rapp, LCSW.

CLIENT NAME (PLEASE PRINT) _____

SIGNATURE_____

DATE_____

NAME OF LEGALLY RESPONSIBLE PARENT OR GUARDIAN (WHERE REQUIRED)

_____

SIGNATURE_____

DATE_____

NAME OF WITNESS _____

SIGNATURE_____

DATE_____