PACIFIC psychology& COMPREHENSIVE HEALTH CLINIC

PORTLAND
1411 SW Morrison St., Suite 310
Portland, OR 97205
503-352-2400

HILLSBORO
222 SE 8th Ave., Suite 212
Hillsboro, OR 97123
503-352-7333

Self-Pay Agreement of Services

Attestation of Acceptance of Terms:

Based on your eligibility for discounts offered by Pacific Psychology and Comprehensive Health Clinic, at this time your fee schedule is as follows:

Therapy intake & feedback session, comprehensive assessment, or first medical services appointment:

$ _____

Therapy sessions or medical services follow-up appointments:

$ _____

If, at any time, you believe your eligibility has changed, please do not hesitate to inform us. We are committed to providing you with quality care at affordable rates.

Cancellation / Lateness Policy:

Pacific Psychology and Comprehensive Health Clinic maintains a 24-hour cancellation policy. If you cancel within 24 hours or do not present to your appointment, you may be charged a $10 late cancellation fee. Being over 15 minutes late for your appointment might result in an automatic no-show. Three or more late cancellations and/or no-shows within three months might result in being put on hiatus from receiving services.

Please **initial below** to indicate your understanding of, and agreement with, the following:

_____ I agree to pay the amounts listed above at the time of service(s).

_____ I understand the terms of the discount I am receiving.

_____ I am aware of the late-cancellation & no-show policy, and understand I will be charged $10 if I cancel an appointment within 24 hours or do not present to my appointment.

_____ I agree to provide documentation of my income or student/veteran ID every 12 months for as long as I am receiving services.

_____ If I choose not to apply for an income based discount, I will be charged the full rate as detailed on the PCH self-pay chart.

I understand and agree to abide by the Self-Pay Agreement described above, that the information provided to PCH is accurate for income-based, student and veteran discounts and that I have disclosed to clinic staff if I have insurance.

Client Name	Client Signature	Date

Legal Representative Name	Legal Representative Signature	Date

Pacific University Oregon