

# Creating Change Psychological Services, PLLC

**Dr. Eugena K. Griffin**

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Licensed Clinical Psychologist  
State of New York (No. 018917)

## PSYCHOTHERAPY SERVICE AGREEMENT

This agreement is written to state the terms of the psychological services provided, fees, and responsibility of psychological service provider, Dr. Eugena K. Griffin. You have requested a Psychological Evaluation to access and qualify alleged symptoms with the intent of receiving treatment in the form of Individual Psychotherapy. Thus, the following services will be executed on

\_\_\_\_\_ (today's date):

1. Structured Clinical Interview
2. Mini-Mental Status Exam
3. Assessment of Appropriateness for Individual Psychotherapy

Upon completion of the initial evaluation (approximately 1-2 hours), a decision will be made regarding the appropriateness for Individual Psychotherapy. Based on the information gathered above, a treatment plan will be devised with the client's input. Such will include meeting time, duration, and short-term & long-term goals.

Please note information discussed in evaluation and/or psychotherapy sessions remain **confidential** and **will not** be shared with guardian(s) and/or any other persons. Information discussed within session is only disclosed if client presents as a threat to self or others and/or if evidence of child abuse/neglect is exhibited. Additionally, at anytime the client's presenting concerns develop beyond the scope of what the provider can treat, a referral to another provider/agency will be made that can best meet the client's needs. Once referral and/or termination of therapeutic relationship is made, provider no longer assumed responsibility for continuing treatment.

\_\_\_\_\_ (Client/Guardian Signature)

**Fee for services, including evaluation and individual therapy sessions are**

**\$125 per 45-50 minutes**

**\$150 for the initial evaluation**

**Payment in debit or credit card**  
**is due at the end of each session**

**Patient is in agreement to pay out of pocket, rather than find provider within the insurance network.**

Also, a patient agrees to pay \$35 when he or she:

- Intends to reschedule an appointment but fails to contact provider at least 24 hours before the appointment, or needs to cancel within 24 hours of set appointment.
- Arrives more than 20 minutes late for an appointment.
- Fails to report for an appointment for any reason.

I acknowledge and agree to the Psychological Service Agreement noted on pages 1 & 2:

Client/Legal Guardian: \_\_\_\_\_  
*Printed Name & Date* *Signature*

Client/Legal Guardian: \_\_\_\_\_  
*Printed Name & Date* *Signature*

Client's Contact Information:

\_\_\_\_\_  
*Street* *City* *State* *Postal Code*

\_\_\_\_\_  
*Telephone* *Email*

**NATIONAL CRISIS HOTLINES**

**1-877-YOUTHLINE**  
*(1-877-968-8454)*  
Youth America Hotline-  
Counseling for Teens by Teens

**1-800-SUICIDE**  
*(1-800-784-2433)*  
National Hopeline  
Network

**1-800-273-TALK**  
*(1-800-273-8255)*  
National Suicide  
Prevention Lifeline