Rory Fleming Richardson, Ph.D., ABMP, TEP

P.O. Box 128, Seymour, Missouri 65746
drrory@live.com

Patient Information

Patient's Name:_____

Address:_____

City, State Zip:_____

Phone: Home_____ Work_____

Social Security Number:_____ Date of Birth:_____

Primary Care Physician:_____

Who to contact in case of an emergency?_____

Relationship:_____Phone_____

Nearest Emergency Room:_____

Person responsible for the account:_____

I, the undersigned, authorized Rory F. Richardson, Ph.D. to provide assessment and treatment services. Services are provided at the hourly rate of $150 per hour payable prior to session. An hour is defined as 50 minutes. For psychological and neuropsychological testing, the time necessary for scoring, interpretation, and preparation of psychological or neuropsychological reports is billed at the same rate.

If court testimony or a deposition is required, a minimum fee of $1500 for each appearance and any travel expenses must be paid prior to the court appearance. If the court appearance or deposition requires travel or time out of the office greater than four hours, each additional hour will be charged at $200 per hour.

The no-show charge for missed appointments is at the full hourly rate for the full length of the scheduled appointment. Cancellations must be called in to Dr. Richardson's office 24 hours prior to the scheduled appointment time to avoid no-show charge.

I authorize the release of any psychological and medical information necessary to process this claim. I also authorize payment of medical benefits to Rory F. Richardson, Ph.D. I understand that I will be responsible for payment of any balance, co-payment or deductible not paid by my insurance coverage.

_____ _____

Responsible Party *Date* *Clinic Staff* *Date*