Julie A. Kriegler, Ph.D.
License # PSY11473

800 Menlo Ave, Suite 209
Menlo Park, Ca 94025

Treatment Agreement

I _____ understand and agree to the fact that I will be seen by Dr. Kriegler ____ times per week and that the charge for these weekly sessions will be _____ per hour. I also understand that I will be charged for my scheduled sessions unless I have provided 48 hours advanced notice of my absence or become ill within the 48 hour period leading up to my scheduled session.

I have been informed and understand that Dr. Kriegler does not provide for or work with any insurance companies. The payment of all fees at the rate agreed to at the beginning of treatment and specified above are solely my responsibility and are due at the completion of every session unless Dr. Kriegler and I have made other agreements. I will be provided with a monthly invoice with all of the information necessary to submit this invoice to my insurance company if I so choose. I understand that beyond this, Dr. Kriegler has no involvement in the setting or recovering of reimbursements for the fees that I pay to her.

_____ _____

Signature Date