DR. NICOLE JOSEPH
LICENSED CLINICAL PSYCHOLOGIST
Psychological Services for Your Best Quality of Life

Dr. Nicole Joseph, PLLC
8618 Westwood Center Drive
Suite 430
Vienna, VA 22182
(703) 772-7822

Payment Agreement

*****PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED *****

Dr. Nicole Joseph accepts payments by cash, check, Visa/MasterCard/Discover credit card, and debit card only.

Insurance: Your confidentiality should be protected and decisions about your treatment should be solely up to you and Dr. Nicole Joseph. For these reasons, Dr. Joseph does not participate with specific insurance plans. Depending on your plan, Dr. Joseph can provide you with a statement of services so that you may seek reimbursement from your insurance company independently. It is your responsibility to check your specific benefit plan to determine if reimbursement is available.

Professional Fees:

Fees are subject to change at any time, with two weeks' advance notice by Dr. Joseph.

One time, 15-minute phone consultation: FREE

Individual Therapy: $135/50 minutes

Couples' or Family Therapy: $150/50 minutes

Group Therapy: $75/50 minutes

Phone Calls: After 10 minutes, prorated at your usual fee

Report Writing: Prorated at your usual fee

Consulting with Professionals about your case:
After 10 minutes, prorated at your usual fee

Preparation of records or treatment summaries:
After 10 minutes, prorated at your usual fee

Time spent performing any other service you may request of me:
After 10 minutes, prorated at your usual fee

Copying or Transfer of Records: $15.00 for records thirty (30) pages or less in length
$30.00 for records exceeding thirty (30) pages
(Payment is due in full prior to the copying and forwarding of records)

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Court Appearances: If you become involved in legal proceedings that require Dr. Joseph's participation, you will be expected to pay for all professional time including preparation and transportation costs, even if called to testify by another party. Because of the difficulty of legal involvement, I charge $250.00 per hour (with a minimum engagement of three (3) hours) for preparation for and attendance at any legal proceeding.

*I have read and agree to the above professional fees policies.
Client/Guardian Initials and Date: _____

Cancelled/Missed Appointments/Other Fees:

No Show Charge: Full Fee

Cancellation less than 24 hours in Advance: $85

Cancellation less than 48 hours in Advance: $50

Reschedule Fee: (rescheduled for different day or hour in same week): $12

Returned Check Fee: $35.00/each returned check

Inclement Weather Cancellations: Unfortunately, Dr. Joseph is unable to offer reimbursement or change cancellation policies even for inclement or unexpected weather events. If you suspect that inclement weather will affect the scheduled session, please cancel/reschedule as soon as possible.

Client Discharge/Collection Fees: In the event of failure to pay for services and fees, you understand that you may be discharged from the services of Dr. Joseph until such time as your account is fully paid.

If your account has remained unpaid for more than 60 days and arrangements for payment have not been agreed upon, Dr. Joseph has the option of using legal means to secure payment. This may involve submitting the account to a collection agency or filing a claim in small claims court, either of which will require that otherwise confidential information be disclosed for the purposes of collecting payment.

You will be responsible for paying the entire amount of your balance due ***in addition*** to all collection fees, all agency and attorney fees and costs associated with the collection process (such as court costs).

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*I have read and agree to the above cancelled/missed appointments, and other fees, to include client discharge/collections fees and procedures.
Client/Guardian Initials and Date: _____

Overall Financial Agreement:

I agree that this financial relationship with Dr. Nicole Joseph will continue as long as Dr. Joseph provides services or until I inform her, in person or by certified mail, that I wish to end it. I agree to meet with Dr. Joseph at least once before stopping therapy. I agree to pay for services provided to me (or this client) and fees up until the time I and Dr. Joseph agree the relationship has terminated.

I agree that I am responsible for the charges for services provided by Dr. Joseph to me (or this client), although other persons may make payments on my (or this client's) account.

I will provide Dr. Nicole Joseph with current mailing address and phone numbers, as well as notification when there are any changes to this information as soon as possible.

*I have read and understand the above Financial Agreement, and agree to abide by the terms of this agreement.
Client/Guardian Initials and Date: _____