Feeling Doctor
Psychotherapy, APC

A. Robin Aylor, Ph.D.
Licensed Clinical Psychologist
PSY 16291

Parental Consent and Payment Agreement

I am the parent of ___________________________________ DOB____________________

I understand that my adult child has agreed to enter into individual therapy with Dr. Robin Aylor.

I agree to allow my child to use their health insurance benefits for these therapy appointments.

I am aware that my child could potentially receive a mental health care diagnosis that could be potentially deleterious and could possibly affect their ability to get other insurances in the future (for example, a diagnosis of Major Depressive Disorder can affect the ability to get Life Insurance in the near future).

As my child is a student and unemployed, I realize that I will be responsible for any medical bills that my child incurs, including fees for late cancellations and "No Show" appointments. It is not the policy of Dr. Aylor to engage in problematic financial struggles between two separated parents. Billing will be made only to one parent, and that will be the parent signing this agreement.

I understand that as a matter of business policy, Dr. Aylor will bill the full billable fee for late cancellations and "No Show" appointments. As "unfair" as this may seem, please recall that each appointment scheduled is booked exclusively for your child. Unlike other health practitioners, therapists cannot cut their time short to fit in an extra patient or overbook their schedules anticipating a certain number of "no show" appointments or cancellations. There is a generous 24-hour cancellation policy, but cancellations in less than 24 hours will be billed at the maximum rate allowable by your insurance carrier. As this rate varies from carrier to carrier, an exact amount cannot be given here.

I understand that a therapist, while operating in a role of caring and compassion is also conducting a business, and as such will expect payment rendered at the time of service.

I agree to provide my child with checks written out to A. Robin Aylor, Ph.D. for any services scheduled in advance or to put money into a debit account that can be charged at the time of service by Dr. Aylor.

_______________________________________ _______________________

Signed dated

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Name Printed

Mailing Address:
P.O. Box 17025
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