

**PSYCHOLOGICAL ASSESSMENT PAYMENT AGREEMENT**

**Client First Name:** \_\_\_\_\_

**Client Last Name:** \_\_\_\_\_

**Client DOB:** \_\_\_\_\_

**Date of Testing Appointment:** \_\_\_\_\_

By submitting this form, I agree to provide a \$500 down payment (to be charged 48 hours prior to the appointment) with the payment source on file to hold the scheduled assessment appointment for the aforementioned client. In the event I need to cancel or reschedule this appointment or any follow-up appointments, I agree to give 48-hour advance notice. If I fail to provide advance notice for a missed/cancelled appointment, I agree to be charged a \$100 late cancel/no-show fee (and will be returned the remaining \$400 if that has already been charged). If I do abide by the terms of this agreement, I understand I will be reimbursed any amount paid in excess of the final cost.

\_\_\_\_\_  
**Client or Representative Signature**

\_\_\_\_\_  
**Date**