Kathleen Doherty Robinson PsyD LLC
Licensed Psychologist #2284
1720 S. Bellaire, Suite #203
Denver, CO 80222
303-782-0433

Parent / Guardian Financial Responsibility Form for Adult Children

I understand that my adult child has decided to enter into a therapeutic treatment contract with Kathleen D. Robinson, Psy.D. and I agree to financially support the therapy with Dr. Robinson. I acknowledge that the information my child shares with Dr. Robinson is legally confidential and cannot be disclosed to me without written consent.

I agree that I will not attempt to engage Dr. Robinson in any legal proceedings, including agreeing to not subpoena Dr. Robinson to testify, disclose any treatment information or write any legal reports.

I agree that Dr. Robinson's fee for psychotherapy, consultation, and evaluation (including test scoring, report preparation, phone consultations/calls, e-mail exchanges, etc. 15 minutes or longer) is $200.00 per 45-minute session. The regular fee will be charged unless notification of cancellation is provided at least 48 hours before the scheduled appointment. I agree that payment is due at the time of service unless I have made prior arrangements with Dr. Robinson. If I chose to make payment using a credit card, I understand that a 3% processing fee will be applied to each transaction. I also understand that Dr. Robinson will not bill my insurance company and does not do any electronic billing. I agree that I am responsible for seeking reimbursement from my insurance company after submitting payment to Dr. Robinson. I understand and agree that a $25.00 fee will be assessed to balances 30 days past due and a $25.00 fee will be assessed for returned checks. I understand that any Balance Due after 60 days will be charged a finance charge of 24% per annum. I understand and agree that if I do not provide payment in full Dr. Robinson will refer my account to a collection agency.

_____	_____
Print Client's Name	Print Name of Parent/Guardian/Responsible Party
_____	_____
Signature of Client	Signature of Parent/Guardian
_____	_____
Kathleen D. Robinson, Psy.D.	Date

If signed by Responsible Party, please print name and state relationship to client and authority to consent:

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