Dr. U. Koechling Psychology Corporation
Cell: 250-213-2331 **Fax:** 250-744-0200 **Phone:** 250-744-0008

Fee Arrangement For

The Provision of Psychological Services

Fees

I, _____, agree to pay Dr. Ulrike Koechling, R. Psych. for all psychological services provided to me at the rate of $_____ per hour.

I agree to pay Dr. Ulrike Koechling, R. Psych. in full for each session at the commencement of each session, unless another arrangement is agreed upon. Unless otherwise agreed, each session is for one hour.

Cancellations

I agree that if I cannot make a scheduled appointment that I must provide Dr. Ulrike Koechling with at least 24 hours notice. If I fail to do so, I acknowledge and agree that I will be charged, and I agree to pay the usual fee for the cancelled appointment.

I understand that I can contact the office telephone number, (250)744-0008, at any time, 24 hours a day to make, change or cancel an appointment, or so that I can contact Dr. Ulrike Koechling in case of emergency.

I have read and understood this agreement and I have received a copy of it. I herby agree to its terms.

Signed and agreed at _____, British Columbia, this _____ day of _____, 20_____.

_____

Client Signature

Private and Confidential

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