

**Pyrysys Psychology Group, Inc.**

8950 Villa La Jolla Drive, Suite B214

La Jolla, CA 92037

Initial Clinician: \_\_\_\_\_

Client Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ E-mail address: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Employer Name (Client or, if client is a minor, guardian's employer): \_\_\_\_\_

Employer Phone: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Spouse Phone: \_\_\_\_\_

Spouse Address: \_\_\_\_\_

In Case of Emergency, Notify: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

May we add your email address to our mailing list (3-6 emailings per year)?  Yes  No

Who may we thank for referring you? \_\_\_\_\_ Phone: \_\_\_\_\_

I, the undersigned, accept full financial responsibility for the cost of all services rendered to the client and attest that the information given is true and correct. I agree to pay a service charge of 0.833% per month (10% per year but not to exceed the maximum rate by law, plus a \$5.00 rebilling charge) to be added to all charges not paid within 30 days from the date of service. I shall pay Pyrysys Psychology Group, Inc. on demand all costs including reasonable attorney fees and collection costs incurred in collecting payment due for services performed under this agreement. I understand that regardless of what any insurance company or other third party may reimburse, I am ultimately responsible for this bill. I agree to pay a \$25 service charge for all checks returned unpaid by my bank. **I UNDERSTAND THAT 48 HOURS NOTICE FOR AN APPOINTMENT CANCELLATION IS REQUIRED OR I WILL BE BILLED AT REGULAR RATE FOR THAT TIME.** If client is a minor, I will be financially responsible for this bill and I give consent for treatment.

Any dispute as to malpractice will be determined by submission to arbitration as provided by California law and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration. Agreeing to arbitrate all disputes that are connected with this treatment is not necessary in order to be treated. If the client or the undersigned does not want to agree to arbitration, he/she should initial here \_\_\_\_\_ now or send a written notice within 30 days from today saying that he/she no longer agrees to arbitration.

Person accepting full financial responsibility for client's account per above agreement:

\_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Signature)

Billing Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

(Over for privacy information)

Please help us protect your privacy by checking the appropriate boxes:

- |                             |                                 |  |
|-----------------------------|---------------------------------|--|
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages on my <b>HOME</b> answering machine.        |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages with any other person.                      |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages on my <b>WORK</b> voice mail.               |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages with co-workers.                            |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages on my <b>CELL PHONE</b> voice mail.         |
| <input type="checkbox"/> Do | <input type="checkbox"/> Do not | leave messages with any other person answering cell phone. |

## **UNDERSTANDING PSYCHOTHERAPY AND CONSENT TO TREATMENT**

### **Consent to Treatment**

The success of psychotherapy depends upon a high degree of trust between us. We therefore want you to be fully informed about what to expect from us and from your sessions here.

### **Our Staff**

All staff work under the supervision of Dr. Horvath (PSY7732). In addition to other psychologists and postdoctoral psychology fellows, the staff at Pырsys Psychology Group, Inc. includes counselors and specialists in alternative health (yoga, bodywork, meditation, etc.).

### **Understanding Psychotherapy**

During initial visits the emphasis will be on understanding the nature of your personal problems and on creating a plan of treatment. Psychotherapy will consist largely of an ongoing dialogue between you and your therapist(s) about 1) problematic behavior, feelings or attitudes, which may be deeply entrenched, 2) what new behaviors, feelings or attitudes you might adopt; and 3) how you might adopt them. Our training, resources, and experience will be used to help you identify, select, and accomplish these desired changes.

You may be given homework assignments, which help carry on our work between sessions. These assignments may include reading, keeping records of behaviors, feelings or attitudes, or experiencing new activities. Any difficulties in accomplishing these assignments should be reported promptly, so that we may develop assignments that you will be able to accomplish.

We encourage you to ask questions at any time. The more deeply you understand what we are doing, the more effectively you will be able to cooperate with it and accomplish the changes you desire. We will evaluate the effectiveness of our work on an on-going basis. By mutual agreement with your specific psychotherapist, if you bring a blank audiocassette, a recording of your session can be made for you.

Psychotherapy is not magic. Your persistence in carrying out homework assignments will have a determining role in how much you accomplish. In particular, the extent to which you are open and honest about yourself will determine how accurately we can assess your situation and recommend appropriate methods and goals.

There can be discomfort involved in participating in psychotherapy. You may remember unpleasant events, or have aroused intense feelings of anger, fear, anxiety, depression, frustration, loneliness, helplessness, or other unpleasant feelings. Homework assignments can at times be uncomfortable. Your family and friends may need time to adjust to changes you make.

In addition to accomplishing your stated goals, there may be additional benefits to participating in psychotherapy, including greater maturity as a person, better understanding of personal goals and values, improved ability to relate to others, and greater self-confidence, self-respect, and self-acceptance.

If you arrive a few minutes ahead of your appointment time, you will have the opportunity to set aside the irrelevant concerns of the day, and prepare for your session.

### **Confidentiality**

In accordance with professional ethics and California law, the information revealed in psychotherapy is confidential, and will not be revealed to anyone without your written permission, except as required by law. California law requires that we make appropriate reports if you are suicidal, homicidal, or gravely disabled, or if any child or elder adult has been abused or neglected.

### **Medications and Medical Procedures**

Psychologists are not physicians, and do not prescribe medication or perform medical procedures. If evaluation by a physician is indicated, we can recommend one, or you may consult your personal physician.

### **Emergencies**

Your psychotherapist or the colleague providing coverage for your therapist can be reached at any time by calling our answering service (858-569-2796) and paging. However, you will likely be charged for this call. Routine business, including the making of appointments, can often be handled during normal working hours by the administrative staff, by calling 858-546-1100.

### **Fees**

Except in cases of emergency, you will be expected to pay for appointments not canceled at least 48 hours in advance. Your appointment time is set aside specifically for you, and cannot usually be given to someone else with less than 48 hours notice.

We charge by the hour for our services. In addition to the time spent directly with you in the office, we charge for any other time spent on your behalf, including telephone calls with you or others, reading or writing documents, doing research, meetings with others, or other activities. Please see the administrative staff for current hourly rates for each provider.

Surcharges for special services may apply. Whenever feasible you will be informed if surcharges apply. The most common surcharges are for deposition, testimony, or after hours services.

Please sign below to indicate that you understand and agree to the above, and consent to treatment. We recommend that you keep a copy of this form, and refer to it from time to time during our work together.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

# Pyrysys Psychology Group, Inc.

8950 Villa La Jolla Drive, Suite B214  
La Jolla, CA 92037  
Tel: (858) 546-1100  
Fax: (858) 455-0141

A. Thomas Horvath, Ph.D., ABPP, President  
California Psychology License PSY7732  
www.pyrysys.com

## Required HIPAA Notice of Privacy Practices

**I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IT WILL GENERALLY PROTECT YOUR PRIVACY TO A MUCH GREATER DEGREE THAN REQUIRED BY THE LANGUAGE OF THE DOCUMENT.**

**II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)**

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you which I have created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of the health care. I must provide you with this Notice about my privacy practices and such Notice must explain how, when, and why I will “use” and “disclose” your PHI. A “use” of PHI occurs when I share, examine, give, or otherwise divulge to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. I am legally required to follow the privacy practices described in this Notice; however, I reserve the right to change the terms of the Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office.

**III. HOW I MAY USE AND DISCLOSE YOUR PHI**

I will use and disclose your PHI for many different reasons. I will need your prior written authorization for some of these uses or disclosures; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

**A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.** I can use and disclose your PHI without your consent for the following reasons:

**For Treatment.** I can use your PHI within my practice to provide you with mental health treatment including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your case. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

**To Obtain Payment for Treatment.** I can use your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

**For Health Care Operations.** I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who have provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

**For Patient Incapacitation or Emergency.** I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent is not required if you need emergency treatment as long as I try to get your consent after treatment is rendered; or, if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

**B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization.** I can use and disclose your PHI without your consent or authorization for the following reasons:

- When federal, state, or local laws require disclosure.** For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to governmental agencies and law enforcement personnel about victims of abuse or neglect.
- When judicial or administrative proceedings require disclosure.** For example, I may have to use or disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or claim for workers’ compensation benefits. I may also have to use or disclose your PHI in response to a subpoena.
- When law enforcement requires disclosure.** For example, I may have to use or disclose your PHI in response to a search warrant.
- When public health activities require disclosure.** For example, I may have to use or disclose your PHI to report to a governmental official an adverse reaction that you may have to a medication.
- When health oversight activities require disclosure.** For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.
- To avert a serious threat to health or safety.** For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. Any such disclosures will only be made to someone able to prevent the threatening harm from occurring.
- For specialized government functions.** For example, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations, if you are in the military.

8. **To remind you about appointments and to inform you of health-related benefits or services.** For example, I may have to use or disclose your PHI to remind you about your appointments or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

**C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

Disclosures to family, friends, or others: I may provide your PHI to a family member, friend, or other person that you indicate that is involved in your care or the payment for your health care unless you object in whole or in part. The opportunity to consent may be obtained retroactively in an emergency situation.

- D. Other Uses and Disclosures Require Your Prior Written Authorization.** In any situation not described in sections III A, B, and C, above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I have not taken any action in reliance on such authorization) of your PHI by me.

**IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

You have the following rights with respect to your PHI:

- A. The Right to Request Restrictions on My Uses and Disclosures.** You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members, friends, or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests but am not legally required to accept them. If I do accept your requests I will put them in writing and will abide by them except in emergency situations. Be advised that you may not limit the uses and disclosures that I am legally required to make.
- B. The Right to Choose How I Send PHI to You.** You have the right to request that I send confidential information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.
- C. The Right to Inspect and Receive a Copy of Your PHI.** In most cases, you have the right to inspect and receive a copy of the PHI that I have on you, but you must make the request to inspect and receive a copy of such information in writing. If I do not have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.
- D. The Right to Receive a List of the Disclosures I Have Made.** You have the right to receive an Accounting of Disclosure listing the instances in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use; disclosures permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; and, disclosures made before April 14, 2003. I will respond to your request for an Accounting of Disclosure within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year I may charge you a reasonable, cost-based fee for each additional request.
- E. The Right to Amend Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide, in writing, the request and your reason for the request. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you do not file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request to amend your PHI, I will make the changes, tell you that I have done it, and tell others that need to know about the change to your PHI.
- F. The Right to Receive a Paper Copy of This Notice.** You have the right to receive a paper copy of this notice even if you have agreed to receive it via e-mail.

**V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you think that I may have violated your privacy rights, or you disagree with a decision I have made about access to your PHI, you may file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S. W., Washington D. C. 20201. I will not take retaliatory action against you if you file a complaint about my privacy practices.

**VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES:** Ana Ferraro, Office Manager: (858) 546-1100, ext. 235.

**VII. Effective Date of This Notice**

This notice went into effect on April 14, 2003.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES**

I, \_\_\_\_\_, have received a copy of Pyrsys Psychology Group, Inc.'s Notice of Privacy Practices.

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**You may refuse to sign this acknowledgement**

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**For Pyrsys Psychology Group, Inc. Use Only**

We made every attempt to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

\_\_\_\_\_ Above named individual refused to sign

\_\_\_\_\_ Emergency situation prevented obtaining signature

\_\_\_\_\_ Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# **Pyrysys Psychology Group, Inc.**

## **AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

*Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be non-applicable or specifically not authorized for release. This release is not valid if it does not contain the client's original signature and date sign, or if it has expired as described below. A copy of this signed form will be provided to the patient, if requested.*

\_\_\_\_ **I authorize Pyrysys Psychology Group, Inc. to release to**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

\_\_\_\_ **I authorize the above entity to release to Pyrysys Psychology Group, Inc.**

**The following information from the health records of:**

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ SSN: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

**Covering the periods of healthcare (dates of service):**

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

**For the purpose of:**

\_\_\_\_\_  
(Not required if the disclosure is requested by the patient)

I understand that this will include information relating to (initial, if applicable):

\_\_\_Billing information, including number and type(s) of sessions (including late cancellations and no-shows charged to my account), balance due, payments received, discounts applied, etc., unless otherwise specified below.

\_\_\_Mental health services/psychiatric care.

\_\_\_Assessment and treatment of alcohol and/or drug abuse.

\_\_\_Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) Infection.

**Please indicate specific information that can/cannot be released to party indicated above. If all information may be released, please indicate "all."**

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**If compensation will be received:** I understand that Pyrysys Psychology Group, Inc. may receive compensation for its use/disclosure of the information release pursuant to this authorization.

Client's initials: \_\_\_

**Affirmation of Release:**

I give Pyrysys Psychology Group, Inc. or the named agency above permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have indicated. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization at any time/ any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a client I have the right to access my treatment records during treatment and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearing house covered by the federal privacy regulation or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations.

\_\_\_\_\_  
Signature of the Client/Guardian/Legal Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Signature of Witness/Relationship to Patient

\_\_\_\_\_  
Date Signed

Expiration date: \_\_\_\_\_

(or one year from date signed)

## Summary of Practical Recovery Treatment Programs

The following fees include a \$1600 non-refundable program. Programs may be of any length. Fees are presented for 30 days to allow for comparisons to other programs. With 48 hour notice of discharge fees on account will be refunded, except the non-refundable program fee.

**Please initial one of the following programs:**

### Adult Program

\_\_\_\_\_ \$11,750, plus \$500 refundable security deposit (for unpaid rent, damages, or expenses).  
Initial deposit: \$6,400, balance due by the 10<sup>th</sup> day of service. Includes structured sober living and 1 individual session a day (Mon-Fri).

\_\_\_\_\_ \$16,150, plus \$500 refundable security deposit (for unpaid rent, damages, or expenses).  
Initial deposit: \$8,600, balance due by the 10<sup>th</sup> day of service. Includes structured sober living and 2 individual sessions a day (Mon-Fri).

\_\_\_\_\_ \$20,550, plus \$500 refundable security deposit (for unpaid rent, damages, or expenses).  
Initial deposit: \$10,800, balance due by the 10<sup>th</sup> day of service. Includes structured sober living and 3 individual sessions a day (Mon-Fri).

\_\_\_\_\_ \$24,950, plus \$500 refundable security deposit (for unpaid rent, damages, or expenses).  
Initial deposit: \$13,000, balance due by the 10<sup>th</sup> day of service. Includes structured sober living and 4 sessions a day (Mon-Fri).

\_\_\_\_\_ \$29,350, plus \$500 refundable security deposit (for unpaid rent, damages, or expenses).  
Initial deposit: \$15,200, balance due by the 10<sup>th</sup> day of service. Includes structured sober living and 5 sessions a day (Mon-Fri)

### Private Rehab

\_\_\_\_\_ \$41,000 (estimated; there may be significant additional expenses). \$3200 non-refundable program fee.  
Initial deposit: \$20,500, balance due by the 10<sup>th</sup> day of service. Living expenses are paid on your own and we bring a customized treatment program to you.

### Treatment-in-Residence

\_\_\_\_\_ \$11,000 to \$21,000 (estimated; with additional expense of food and lodging).  
Initial deposit: \$7,500, balance due by the 10<sup>th</sup> day of service. Attend services in our office while staying in the location of your choosing.

### Young Adult Program

\_\_\_\_\_ \$11,750, plus \$500 refundable security deposit (for unpaid rent, damages, or expenses).  
Initial deposit: \$6,400, balance due by the 10<sup>th</sup> day of service. Includes structured sober living and up to one session or coaching per day (Mon-Fri).

\_\_\_\_\_ \$16,150, plus \$500 refundable security deposit (for unpaid rent, damages, or expenses).  
Initial deposit: \$8,600, balance due by the 10<sup>th</sup> day of service. Includes structured sober living and up to 2 sessions or coaching per day (Mon-Fri).

**Printed name** \_\_\_\_\_

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

**Pyrysys Psychology Group, Inc.**  
A Human Services Company  
www.pyrysys.com

8950 Villa La Jolla Drive, Suite B214  
La Jolla, CA 92037  
Tel (858) 546-1100  
Fax (858) 455-0141

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**Deposit Agreement and Credit Card Authorization**

I, the undersigned, agree to pay Pyrysys Psychology Group, Inc. (PPG) \$\_\_\_\_\_ to hold a place in a PPG intensive program (as per attached summary of Practical Recovery Treatment Programs) for me or the person(s) listed below, for whom I accept full financial responsibility. \$1,600 of this deposit is for a non-refundable Program Fee which is for 4 weeks of all services coordination and, thereafter, the Program Fee is to be charged \$400 weekly. \$200 of this deposit is for a non-refundable Basic Psychological Testing Fee; additional psychological testing and interpretation, if necessary, will be charged to my account. Services may include, but are not limited to: psychological assessment, testing, and treatment, service/care coordination or other time spent on behalf of a client without the client being present, or other ancillary or alternative health services such acupuncture or massage. At the end of treatment, any credit balance on my account will be credited back to my credit card. I or the person(s) listed below may withdraw from treatment at any time but my credit card will be charged in full for any appointments not cancelled at least 48 hours in advance. I have the right to terminate this deposit agreement and credit card authorization at any time but must do so in writing via mail or hand-delivery to 8950 Villa La Jolla Dr., B214, La Jolla, CA, 92037, or fax to 858-455-0141. The termination is effective 48 hours after PPG receives my termination letter. If I fax my termination letter to PPG, I will mail the signed original to the above address on the same day.

I authorize PPG to keep my signature on file and to charge my credit card listed below per the terms of the above agreement plus the balance of \$\_\_\_\_\_ due on the 10<sup>th</sup> day of service plus any additional charges for my ongoing treatment.

\_\_\_\_\_  
(authorized person)

\_\_\_\_\_  
(authorized person)

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Check one:     VISA®     American Express®     MasterCard®  
                   Discover® Card     PulseCard® (the healthcare credit card)

Cardholder Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

❖ Charge will appear on credit card statement as "PPG INC"