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### **Doctor – Patient Agreement**

I am aware that an appointment represents a mutual commitment between myself and the doctor and that I am responsible for payment for the time set aside for me unless a week's notice of cancellation is given in advance.

I understand that I am responsible for the payment of my account. I understand that payment for services rendered is due at the time of service. With this arrangement, the doctor can lower her fee due to fewer secretarial hours. I understand that this agreement represents a two person contract and that should I wish to pay each session by credit card, Dr. Munschauer's bookkeeper may bill my card on the day of service.

\_\_\_\_\_ Date: \_\_\_\_\_  
Patient/Responsible Party

\_\_\_\_\_ Date: \_\_\_\_\_  
Carol A. Munschauer, Ph.D.