GRANOFF THERAPY & CHAGRIN BRAIN TRAINING CENTER
David L. Granoff, Psy.D. - *Clinical Psychologist & NeurOptimal® Neurofeedback Specialist*

21403 Chagrin Blvd. #210, Beachwood, Ohio 44122
(216) 752-5346

www.granofftherapy.com • www.chagrinbraintraining.com

NEW CLIENT INTAKE FORM

Client Name: _____

Date of Birth: _____

Person Responsible For Payment: _____

Address:_____
street number street city zip code

Phone: Home _____ Cell _____Work _____
please circle phone numbers where messages can be left

E-mail address: _____

Relationship to Client: _____

Occupation: _____

Place of Employment:_____

If Client is a Minor:
School:_____Grade:_____

If Client and Person responsible for payments are different and client may be scheduling own appointments, please also give phone and e-mail for client:
Phone: _____
e-mail:_____

Referred By: _____
Initial below, if you would like to give me permission to communicate with this person.
_____

PROFESSIONAL SERVICES AGREEMENT
David L. Granoff, Psy.D.

The Ohio State Psychology Board requires that all clients are fully informed regarding the costs of professional services. The following is a list of fees and my cancellation policy. Please read this material carefully and sign below to signify your acceptance of these terms.

FEES:

Appointments with Dr. Granoff for therapy and/or NeurOptimal® Neurofeedback:

Initial Consultation:	$225
Office Visit (50 minutes):	$200
Telephone Consultation:	Office Visit Rate, Pro Rata

Appointments with an assistant for NeurOptimal® Neurofeedback:

Initial Consultation:	$125
Office visit - weekday (50 minutes):	$100
Office visit - Saturdays (50 minutes):	$125

Train your brain at home - Neurofeedback system rental:
Ideal for training multiple family members. Includes unlimited sessions.

Monthly Rental Fee:	$900

CANCELLATION POLICY:

Initially I require a 24 hour notice for a cancellation or you will be charged for the session. After 2 cancellations, this policy may be altered within our therapeutic discussion.

PAYMENT:

I am a fee for service provider. In choosing to work with me, my clients accept responsibility to pay directly for my services. I no longer accept health insurance.

Payment is required as services are delivered unless we discuss and agree upon an alternative arrangement. Payment can be made via cash, check or credit card (Master Card, Visa or Discover).

I require a credit card on file. In the event of a forgotten checkbook or missed appointment a session charge will be placed on the following credit card account:

VISA MasterCard Discover
(Please circle the name of the card that you are using.)

Credit Card 16 Digit Number:_____

Expiration Date: _____ 3 Digit Security Code:_____

AUTHORIZATION:

By signing below, I am confirming that I have read and understand the above conditions and I accept full financial responsibility for frees incurred within the framework of this agreement. I have also received the Privacy and Confidentiality Notice Form (linked on the website).

_____
Name (print)

_____ _____
Signature Date

_____ _____
Signature Date