From the Office of
Michael J. Keenan, PH.D.
Clinical Psychologist

PLEASE SIGN AND RETURN BOTH PAGES TO:
drkeenan1@aol.com

Patient's Name: ______________________________

Address: ______________________________

City: ________________ State: __________ Zip: __________–__________

Email Address: ______________________________

Telephone - Primary: ________________ ☐ Cell ☐ Office ☐ Home

Alternate: ________________ ☐ Cell ☐ Office ☐ Home

Alternate: ________________ ☐ Cell ☐ Office ☐ Home

Date of Birth: ________________

Sex: ☐ Female ☐ Male

Marital Status: ________________

Occupation: ______________________________

Employer: ______________________________

How were you referred to me? ______________________________

Emergency Contact: ______________________________

Relationship to you: ______________________________

Telephone - Primary: ______________________________

Alternate: ________________ ☐ Cell ☐ Office ☐ Home

Alternate: ________________ ☐ Cell ☐ Office ☐ Home

Payment for Psychological Service is due AT THE TIME THE SERVICES ARE RENDERED.

CANCELLATIONS: Please call us directly or leave a voicemail 24 hours before your scheduled visit to cancel. If canceling within the 24 hr period, we will make our best effort to fill that spot; however, if we can't fill it, the full session rate will be applied. Please note text/e-mails will not satisfy the cancellation.

"I have read the above payment policies and agree to abide by them."

Signature of Patient: ______________________________ Date: __________

If we need to contact you, where do you want to be called? ______________________________

From the Office of
Michael J. Keenan, PH.D.
Clinical Psychologist
713-521-7244

FEE SCHEDULE

Service	Session	Fee
Diagnostic Examination	40-45 Min. Session	$275.00
Individual Therapy	40-45 Min. Session	$195.00
Family/Couples Therapy	40-45 Min. Session	$250.00
Required Documents, If Agreed Upon		$300/Hr.

HIPPA Requirements - 1 Copy of Payment History Released at no charge.

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RETURNED CHECK POLICY: $50.00 additional fee for each returned check.

CONFIDENTIALITY

THE OFFICE OF DR. MICHAEL J. KEENAN PH.D. PROVIDES SERVICES IN A MANNER THAT SAFEGUARDS YOUR PRIVACY AND CONFIDENTIALITY. THESE COMMUNICATIONS AND RECORDS MAY NOT BE DISCLOSED WITHOUT YOUR WRITTEN CONSENT EXCEPT IF REQUIRED BY LAW.

INSURANCE DISCLOSURE

WE DO NOT ACCEPT INSURANCE. ALL FEES ARE PAID AT THE TIME OF SERVICE. HOWEVER, IF YOU HAVE OUT-OF-NETWORK BEHAVIORAL BENEFITS, WE CAN GIVE YOU A RECEIPT. YOU ARE THEN DIRECTLY REIMBURSED BY YOUR INSURANCE COMPANY ACCORDING TO THEIR REQUIREMENTS, ONCE YOU SUBMIT YOUR RECEIPT TO THEM.

I HAVE CAREFULLY READ THE CONDITIONS ABOVE AND AGREE TO THE TERMS AS STATED.

PATIENT'S SIGNATURE: DATE:

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