AnneMarie Jeffries, PsyD
675 Seminole Ave. Unit T-03
Atlanta, GA 30307
404-620-3149

Fees and Payment Form

I, ________________________ (client) understand and agree that I am responsible for the payment of ______ dollars per 50-minute psychotherapy session with AnneMarie Jeffries, PsyD effective _________ (Date). I understand that I am expected and responsible for paying for each session **at the time it is held**, unless there is another agreement in writing. I also am aware that this agreed-upon fee for Dr. Jeffries' psychotherapy services might be reconsidered six months from the date of this agreement. I am aware that payments can be made via cash, check, or credit card at the time of the appointment.

Credit Card information:

Type of credit card: ________________________________

Credit card number: ___________________________________ Expiration date: ___________

Card security code: _________

Name on Card: ____Billing zip code ______

Insurance Information (If you intend to use out-of-network benefits)

Insurance Company ____

Telephone ____

Mailing address (for mailing mental health claims) _____________________________________

Client signature ____________________________________ Date ____________________

Signature indicates that you agree to allow your therapist to make charges on your card without you present