**Fees and Payment Form**

I, (client) understand and agree that I am responsible for the payment of 225.00 dollars per 55-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