

Jay S. Weinberg, MA, CAGS

NEW PATIENT FORM/NOTICE OF BILLING

Name: _____

Date of Birth _____

Address: _____

Home _____

Cell Phone: Phone:

Work _____

Other: Phone:

*Email: _____

Person Responsible for Payment Information:

Name: _____

Date of Birth _____

Billing Address: _____

Phone Number: _____

Email: _____

Credit Card No. _____ ****See below**

Expiration: _____ CCV _____ Billing

Zip Code: _____

Payments for sessions are due at the time of service. The session rate is \$175.00 for 50- minute sessions, or otherwise agreed upon between the therapist and patient. The rate for initial intake session is \$225. The intake process includes coordination of care with parents of minors and providers. Any missed appointments without 24-hour notice will be billed at the session rate. Telephonic/coaching calls are billed in 15 minute increments at \$3/minute. Accepted forms of payment are cash, checks, Venmo, Zell, credit and health savings account cards. ****Payments made via credit card will incur a \$5.00 processing fee per transaction.**

NOTICE OF BILLING: I/We have read and received a copy of the Notice of Billing:

Signature(s) _____ **Date** _____

Print Name _____ **Relationship to Client** _____