Journey Well Now

B. Ronni Greenberg, Psy.D., PC

3748 N. Ashland Avenue, 1N, Chicago, IL 60613
773/405-6007

NEW CLIENT FEE POLICY & AGREEMENT:

Name: ____

Address: ____

City, State: ____________________________ Zip Code: ______________________

Cell Phone: ______________________ Secondary Contact Number: _____________

Email: __________________________ Birthdate: ___________________________

All Clients MUST Have A Valid Credit Card On File, Even If Paying By Cash Or Check.

Credit Card Information: Card Type: _______________ Exp. Date: ____________

Card Number: ___________________________________ Auth. Code: ___________

Cardholder's Signature: ____

Please read the following policies and initial your consent and acknowledgement of these policies.

I understand that the fee for a session is payable at the time of each session. Sessions cannot be extended for clients who run late. (____)

I understand that I must call to cancel an appointment at least 48 hours before the time of the appointment. If I do not cancel with the required notice and do not show up, I will be charged $100 for that appointment. (____)

All appointments to be canceled or rescheduled must be done by telephone contact (messages on my voicemail are fine). Any cancellations and/or rescheduling done over email or text messages are subject to a late cancellation fee no matter when the email/text was sent. (____)

I understand that any charges incurred to the provider because of a returned check(s) will be paid by me. The minimum charge for a returned check that I have written will $20, in addition to the check amount. (____)

I agree to be responsible for the full payment of my fee, even if I may be submitting my bill to a third party, such as an insurance company. I understand that I am responsible for any services not covered by my insurance provider. (____)

All fees outstanding beyond 60 days will be charged to your credit card. This includes fees your insurance company denied, excluded or unmet deductibles. (____)

I understand that if payment for the services I receive here is not made, the therapist may stop my treatment. (____)

Client Signature: ___________________________________ Date: ______________

Witness Signature: __________________________________ Date: ______________