Christina Z. Atti, Psy.D.
Licensed Psychologist

RESPONSIBILITY OF PAYMENT

• I understand that I am responsible for payment at the time services are rendered and the fee for services are as follows:

- For Individuals:
  - $275 for Initial Evaluation (60 Minutes)
  - $250 for Regular Sessions (45-50 Minutes)
- For Couples & Families:
  - $325 for Initial Evaluation (60 Minutes)
  - $300 for Regular Appointments (45-50 Minutes)

• If I feel that I am unable to pay the full amount per session, I understand that I may speak to Dr. Atti about receiving services at a reduced fee which is done on a case-by-case basis.

• Payments may be in the form of cash, check, and/or credit cards.

• I recognize that my appointment is a time that is scheduled specifically for me and that it is of utmost importance to make every effort to attend. In the event that I cannot make a previously scheduled appointment, I will respectfully notify Dr. Atti at least 24-hours in advance so that she may provide services to another client at this allotted time.

• I understand that the fee for missed appointments is the full amount of my session. I understand this cancellation policy and agree to the terms.

• I hereby authorize Dr. Atti to charge my credit card, that is on file, for breaches of her cancellation policy.

_____ _____

Client Signature/Parent or Legal Guardian Signature Date

_____ _____

Christina Z. Atti, Psy.D. Date

Licensed Psychologist, # PY 9167

Christina Z. Atti, Psy.D.
Licensed Psychologist

CREDIT CARD AUTHORIZATION

PATIENT NAME: _____

Cardholder Name :_____ Cardholder Signature: _____

Billing Address: _____

_____

Billing Zip Code: _____

Where would you like receipts sent? (circle one) Email or Text

Email Address: _____

Phone Number: _____

Credit Card Type: _____VISA _____MASTERCARD _____DISCOVER _____AMEX

Credit Card #: _____-_____-_____-_____

Expiration Date: _____/_____

Card Identification # (last 3 digits located on the back of VISA and MASTERCARD): _____

I agree to allow Dr. Atti to charge current and future invoice balances to this credit card. I understand that I am responsible for any unpaid balance. I have read and understand Dr. Atti's fees for service and cancellation policy. I agree to have any current and future unpaid fees charged to the card listed above.

_____ _____

Client Signature/Parent or Legal Guardian Date