Yoffe Therapy
Child & Family Therapy

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CLIENT PAYMENT AGREEMENT

PLEASE SELECT ONE OF THE FOLLOWING PAYMENT OPTIONS BY PLACING AN X IN THE SPACE PROVIDED. If choosing option A, please fill out form below. Please return form with November payment.

PLEASE BILL MY VISA/MASTERCARD/AMEX AFTER EACH SESSION
BASIS $_____

SIGNATURE_____ DATE_____

Please complete this form. Your credit card will be billed after each session. You will receive a superbill once per month via e-mail (please enter e-mail) reflecting services and payment which you may submit to your insurance company.

Client Name:_____
Print First and Last Name

I, _____(name on credit card), hereby authorize Jeanette Yoffe to charge my Visa/MasterCard for psychotherapy services on a monthly basis.

Credit Card Number: _____

Expiration Date: _____ CCV Code on back of card: _____

Address: _____ Zip: _____

Drivers License Number of card holder: _____

Signature of Card Holder _____

Date of authorization _____

EMAIL address: _____