Cherie Baetz-Davis, Ph.D., LLC

BILLING INFORMATION

Client's Name: _____ Birthdate: _____

Payment is expected at the start of each appointment. I understand that appointments must be **cancelled 24-hours in advance**; otherwise I will be **charged $65 for the missed appointment.** If a **collection agency** becomes involved, there will be **an additional recovery fee** charged. Fees are $210 for initial diagnostic sessions, $160 for family or couple's therapy, and $140 for individual therapy sessions. If using insurance, insurance often pays a portion.

Private Pay

Private pay can afford you greater privacy and control in managing your treatment. I will be paying out of pocket.

_____ _____

Client/Guardian Signature *Date*

Insurance Authorization

Primary Insurance: _____ Subscriber's SSN: _____

Policy ID #: _____ Group #: _____ Authorization #: _____

Subscriber's Name: _____ Relation to Client: _____

Subscriber's Employer: _____ Subscriber's Birthdate: _____

Subscriber's Address: _____

Subscriber's Phone: _____ Subscriber's Email: _____

Secondary Insurance: _____ Subcriber's SSN: _____

Policy ID #: _____ Group #: _____ Authorization #: _____

Subscriber's Name: _____ Relation to Client: _____

Subscriber's Employer: _____ Subscriber's Birthdate: _____

I hereby authorize my insurance company to pay medical insurance benefits directly to Cherie Baetz-Davis, Ph.D. for services rendered, and to release any medical and/or mental health information regarding the above named client necessary to process claims. **I understand that I am financially responsible for any required copays, deductibles, or services not covered by my insurer.**

_____ _____

Client/Guardian Signature *Date*

Credit Card Authorization

Cardholder Name: _____ Email: _____

Address: _____

Card Type (*check one*): ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Card #: _____ Exp: _____ CID#: _____

Credit card payments allow payments to be spread out, while making them smaller and easier to keep current. By signing I agree that any outstanding balance on my account **after three months** may be charged to my credit card. A 5% transaction fee will apply. I agree to the above terms and authorize you to charge payment.

_____ _____

Cardholder Signature *Date*

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