Christopher Bauchman, Psy.D.
Licensed Psychologist
11000 Prosperity Farms Rd.
Ste. 202
Palm Beach Gardens, FL 33410
www.drbauchman.com
561-328-7567

Fee Agreement

Client Name:_____ *Date*:_____

I agree that payments or copays for services are due at the time of service and the responsibility for payment is mine. Denial of payment by an insurance carrier or other third party does not waive my responsibility to pay.

____I intend to pay in full for the session or co-payment at the time of services are rendered with:

cash_____ card_____ check_____

I will pay $_____ for the evaluation session and $_____ for ongoing 50- 55 minute sessions.

Credit Card Information – Required

I authorize Christopher J. BH. Bauchman, Psy.D. to charge this account for cancelled and no show appointments:

Card Number:_____

Expiration Date (Month/Year):_____/_____ 3 Digit CID:_____

Name of Card Holder:_____

Signature of Card Holder:_____

Address of Card Holder:_____

Signature of Client:_____ Date:_____

Scheduling Policy (Please initial)

____ I understand that no show or cancelled sessions will be charged to me at the full fee.