Katie M. McCall, PhD
Licensed Clinical Psychologist

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Fee Agreement

Payment Plan:

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

__________________________ intends to pay in full for the session at the time of service with cash/check. I will pay $______________ for the first session and $ ______________ for ongoing sessions.

Scheduling Policy: (Please Initial)

__________ I understand that if I fail to show for a scheduled appointment or if I cancel the appointment with less than 24 hours notice, I will be charged a $100 cancellation fee.

Credit Card Authorization:

I authorize Katie McCall, PhD to charge this account for late cancellations and no show appointments as well as for unpaid balances:

Card Number:____

Expiration Date (Month/Year):___________________ 3 digit CID:____________

Name of Card Holder: ____

Zip Code of Card Holder: ____

Signature of Card Holder: ____

Date: _________________________