Reeva Ramcharan Psy.D.
LICENSED PSYCHOLOGIST
PY9149

RESPONSIBILITY OF PAYMENT

• I understand that the fee for service is $160.00 per 55-minute therapy hour and that I am responsible for payment at the time services are rendered.

• If I feel that I am unable to pay the full amount per session, I understand that I may speak to Dr. Ramcharan 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 or debit 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. Ramcharan at least 24-hours in advance so that she may provide services to another client at this allotted time.

• I understand that appointments cancelled with less than 24-hours' notice or missed appointments are breaches of the cancellation policy. The fee for breaches of the cancellation policy is the cost of the session that is scheduled. I understand this cancellation policy and agree to the terms.

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

_____ _____

Client Signature/Parent or Legal Guardian Signature Date

_____ _____

Reeva Ramcharan, Psy.D. Licensed Psychologist Date
PY 9149

5738 Canton Cove, Suite 110, Winter Springs, FL 32708
Phone (407) 233-5667 www.ReevaRamcharanPsyD.com

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CREDIT CARD AUTHORIZATION

PATIENT NAME: _____

Cardholder Name :_____ Cardholder Signature: _____

Billing Address: _____
_____

Billing Zip Code: _____

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. Ramcharan 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. Ramcharan'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

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