

Jennifer A. Dechert, Psy.D. Counseling & Consulting, LLC.

License NJ#5284 & NY#018990

Third Party Payer Authorization Form

For Completion by Third Party Form

Client Name

DOB

Payer Relationship to Client

Payer Name

Phone Number

Email Address

Billing Address (Street, City, State, Zip)

Payment Information

Name on Card

Type of card (e.g., Visa, Mastercard etc.)

Card Number

Exp. (MM/YY) CVV

Agreement:

By initialing each line, you understand and agree to the following:

_____ I voluntarily agree to assume financial responsibility for the client(s) listed below and agree to pay the therapist's normal rate(s) as well as any additional fees incurred by the client as explained in Dr. Jennifer Dechert's informed consent(s) (e.g., late cancellation fees, court fees, administrative fees etc.).

_____ I am not able to access confidential information regarding the client unless the client provides a signed Release of Information (ROI) with Dr. Dechert. Client will need to sign ROI with Dr. Dechert for Dr. Dechert to be able to discuss any payment/financial matters with anyone.

_____ A financial statement suitable for possible out of network insurance reimbursement will be available upon request and the client's written agreement. It will be provided to client following sessions if applicable.

_____ I will notify Dr. Jennifer Dechert if I need to make a change to payment information, update a credit card, or if I am not longer able/willing to pay for the client's services.

Payer Signature and printed name

Date