JAN WILLER, PH.D.
LICENSED CLINICAL PSYCHOLOGIST
773-859-1822
WWW.DRWILLER.COM

2334 W. LAWRENCE AVE
SUITE 212, CHICAGO, IL 60625

# Credit/Debit Card Payment Consent Form

Patient Name _____
*Print* *Last* *First* *Middle Initial*

Name on Card if different _____

.

I authorize Jan Willer, Ph.D. to charge my card for professional services as follows:

Initial

_____ **For self-pay ADHD assessment:** Fees are as follows:
Two sessions cost per each: $250, one hour of psychological testing: $175

_____ **For self-pay psychotherapy/EF training:** Fees are as follows:
First session: $250, 45 minute session: $175, 55 minute session: $195

_____ **When insurance is applied:** To charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.

Type of Card: ☐ VISA ☐ MasterCard. ☐ Discover

Card Number _____ - _____ - _____ - _____

Exp. Date _____/_____

CVV Number _____ (3 digit # from back of card)

Card Holder's Billing Address for Monthly Card Statements

_____
*Street* *City* *State* *Zip*

Card Holder Signature _____ Date ____ /____ /____
**Please put real signature here, not electronic signature, thanks.**