Susanne Stribling Turner, PsyD
Licensed Psychologist

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Gainesville, GA
30501

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404-586-4878

Payment Authorization Form

Fees (as of 9/1/2022): Clients seen by Susanne Stribling Turner, PsyD, agree to pay $175.00 per 50-minute session or $200.00 for a 75-minute session or $250.00 for first appointments and/or 90 minute sessions. Phone calls for scheduling, rescheduling, or a brief check in are not billed. However, phone calls that are to address therapeutic content or significant change in clinical status need to be scheduled and will be billed as a 30 minute or 50 minute session. Susanne Stribling, Psy.D., LLC reserves the right to announce fee increases, which upon effective date shall become current for all existing clients. Cash, checks and credit cards will be accepted as forms of payment. Please note that there is a $30 fee for returned checks. Should you miss a payment, for whatever reason, therapy sessions may be postponed until the full payment is rendered. You are responsible for the full payment at the time service is provided. All clients are required to provide a credit card number to keep on file in the case of missed appointments or late cancellations. Please see the disclosure regarding the No Surprises Act (1/1/2022) regarding the choice to forgo your use of insurance. All services will be billed through Susanne Stribling Turner, PsyD (DBA Susanne Stribling, Psy.D. LLC).

NEW CANCELLATION POLICY

48 HOURS in advance for cancellations: otherwise the cancellation fee of $100 will be charged. A NO SHOW or same-day cancellation is charged at the full fee of $175.00 for the session.

Monday reschedules must be done by the previous Friday at 12. This is to ensure that all waitlisted clients can be worked in for appointment times.

Please initial to consent to the cancellation policy.

Patient's initials _____

SUSANNE TURNER

I hereby authorize Susanne Stribling, PsyD, LLC to charge my credit card as follows:

Card type (circle) MC Visa Discover Amex

Name on Card_____

CC number_____

Exp Date ___/____

CVC code (on back of card)_____

Address on file for card _____

City_____State___Zip____

I have read, understand and agree to the above fee payment and credit card policy.

_____

Signature & Date

Patient's initials _____

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