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Intake and Credit Card Information:

Date: _____

Name: _____

Address: _____

City, State: _____

Zip Code: _____ DOB _____

Email Address: _____

Phone number including area code: _____

Optional Payment Info.

Type of credit card: _____

Card Number: _____

Expiration Date: _____

CVV number on back of card: _____

I understand this card will be billed for any payments owed to Dr. Steinberg unless it has been paid by insurance, check or cash at the time of service. The first session is \$180.00, and every session after the first is billed at \$160/session. I authorize Dr. Steinberg to bill this credit card to fulfill my payments for psychological services.

Signature

Date