Financial Agreement

Therapy is significant personal investment. You are expected to pay for all services.

		Office Session Fees	In-Home Session Fees
Individual Therapy	(45 min)	$165.00	———-
Individual Therapy	(60 min)	$220.00	$275.00
Couples Therapy	(90 min)	$330.00	$410.00

Payment must be rendered at each session and can be made with cash, debit/credit card, or a personal check. If you have insurance coverage, I will be glad to provide you with a bill you can use to file an insurance claim for reimbursement as your insurance allows. Please see my Office Policies and Informed Consent for more detailed information regarding prorated services greater than 5 minutes.

Payment Information on File

In order to facilitate payment as well as prevent possible involvement with a collection agency, a valid credit or debit card must be maintained on file. You may use any payment method at the time of service. This information is specifically requested to use for no-show appointments, cancellations not made more than 24 hours prior to your appointment. This method may also be used should you otherwise develop an outstanding balance.

Your financial information will be securely maintained, and the information will not be shared with anyone outside of Dr. Romeo's office. If you do not have a valid credit/debit card, a cash deposit or an un-dated, signed personal check with your driver's license or Texas identification number will be accepted. It is your responsibility to provide updates should your financial information such as card number or address change.

Please Select: VISA MC AMEX DEBIT CASH CHECK

Name on Card: _____

Credit Card Number: _____ Expiration Date: _____

Card Verification Code (3-digits on back of card): _____

Billing Address: _____
Street Address

_____
City / State / Zip

Angela Romeo, Psy.D., PLLC 4306 Yoakum Blvd., Ste. 380, Houston, TX 77006 (713) 954-8209
Website: drangelaromeo.com Email: dr_romeo@hushmail.com

Texas ID or Driver's License: _____
(for use with cash or check deposit only)

I understand that I am responsible for payment of all services provided to me by Angela Romeo, Psy.D., PLLC. I authorize use of my payment method provided on page one of this agree for payment of no-show appointments and cancellations not made more than 24 hours in advance. I may also be charged for any other outstanding balances using the same payment method.

_____
Client's Printed Name

_____ _____
Client's Signature Date

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