

KATHRYN S. STEINMAN, PSY.D.
Licensed Psychologist

PREFERRED PAYMENT METHOD

Please indicate your preferred method of payment for services. It is requested that payment be received at the time of each appointment.

_____ Cash

_____ Check

_____ Credit Card (Visa, MasterCard, or Discover)*

*Please note: I require that all patients keep a credit card on file (see related form) even if they will be paying by cash or check.

Patient Signature

Date

Patient Name (Printed)