Megan F. Gerbracht, Psy.D., LLC
EIN: 26-3882474
Virginia License # 0810003894
1489 Chain Bridge Rd., Suite 203 McLean, Virginia 22101
(703) 627-9086

PROFESSIONAL FEES

Patient Name:_____
Responsible Party:_____
Email Address for Billing:_____
Credit Card Billing Address:_____

Fees Per Visit:
$190.00 per 45-minute Therapy/Evaluation session
$250.00 for 60-minutes of Parent Consultation or other professional services
$380.00 per 90-minute Therapy/Evaluation/Consultation Session (i.e. initial parent sessions)

Other professional services may include report writing/reading, telephone conversations lasting 15 minutes or longer, consulting with other professionals with your permission, preparation of records, and the time spent performing any other service you may request of me. I will prorate the hourly cost if I work for periods of more/less than one hour.

Special Pay Arrangements:_____
(Applicable only for clients paying a reduced fee)

Credit Card Payment Options:
All clients must provide credit card information to ensure timely payment. Please **choose one** of the two options below regarding your credit card payment preference by checking the box next to your choice.

☐ **Option #1** I understand that a billing statement will be emailed to me at the beginning of each month and that payment is due by the 25th of each month. If payment has not been received by the end of the month, I understand that my credit card will be charged for the amount due plus a 3% transaction fee. By choosing this option my credit card information will remain on file and will *only be used in the case of late payment*.

☐ **Option #2** I wish to have my credit card charged at the end of EVERY MONTH to pay my balance in lieu of writing a monthly check for payment. I understand that I will be charged a 3% transaction fee if I choose this option. A billing statement and a receipt of payment will be emailed to me at the beginning of each month for my records.

Name as it appears on your credit card:_____
☐ Visa or ☐ Mastercard
Credit Card Number: _ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _ Exp. Date: _ _ / _ _ _ _
Security Code: _ _ _

I hereby Authorize Megan F. Gerbracht, Psy.D. to release information concerning my treatment to my insurance carrier in accordance with the Code of Virginia.

I acknowledge responsibility for this account and guarantee payment of all charges against this account. I understand that this account is my responsibility and not that of my insurance company. I have been informed that Dr. Megan Gerbracht does not participate in any insurance panel(s).

I agree to the above financial terms and consent to treatment for myself and/or my child.

_____
Signature of Responsible Party Date