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Billing/Fees Policy

I, as the client and/or the parent/legal guardian of the client am fully responsible for all payments to Dr. Maker for evaluations, therapy, and psychological testing. I understand that Dr. Maker does not accept assignment of insurance payments. Dr. Maker's standard fee is \$200 for a 45 minutes session and \$200/hour for psychological testing, scoring, report writing, and feedback.

I understand that I will be expected to pay the full fee due for each Evaluation or Therapy session at the end of each session. For Psychological Testing, Dr. Maker will provide me with an estimate of the hours/fee prior to starting testing. I will be expected to pay a 50% deposit of the full amount prior to the testing. The balance will be due the day of the report/feedback session.

I understand and agree to all of the above information.

VISA OR MASTERCARD Credit Card Information: (PLEASE PRINT)

Name on Card: _____

Card Number: _____

Expiration Date: _____

V Code (on back): _____

Billing Address of Card: _____

I authorize Dr. Maker to charge the credit card listed above for all evaluation, therapy, and assessment fees.

Patient (or Parent/Guardian)
Print name above

Date

Patient (or Parent/Guardian) Signature