Susan J. Steinberg, Ph.D., LLC
10597 Montgomery Road   Suite 201
Cincinnati, OH 45242
513-793-6226, ext. 1
www.DrSusanJSteinberg.com

Intake and Credit Card Information:

Date:____

Name:____

Address:____

City, State:____

Zip Code:________________________ DOB ______________________

Email Address:____

Phone number including area code:_________________________________

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 check or cash at the time of service. The first session is $175.00, and every session after the first is billed at $145/session. I authorize Dr. Steinberg to bill this credit card to fulfill my payments for psychological services.

_________________________________ ____________________
Signature Date