Nancy Arnold Payne, MA, LCSW, PLLC

154 West 70th Street, Suite 10A
New York, NY 10023

FEE FOR SERVICE AGREEMENT

By signing below I understand that I am responsible for the total amount indicated (see below; fee /copy/coinsurance) for services rendered. Payment is due at the time of service or monthly, or in the case where Out of Network Benefits are available, upon receipt of a monthly invoice.

Mutually agreed upon fee _____________ OR:

Insurance Carrier:______________________

Copay Y______ N _______ Amount __________

Coinsurance Y _____ N _______ Amount __________

Client Name:

____

Signature:

____Date:_______________