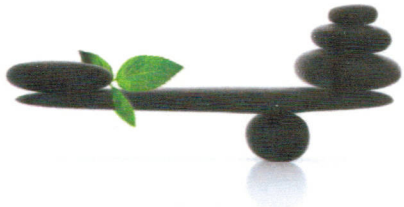
DR. JILL SILVERMAN, PH.D.
LICENSED PSYCHOLOGIST



Payment Policy

PAYMENT IS EXPECTED AT THE TIME OF VIST. Any accounts that are 90 days past due may be referred to a collection agency for further handling. An itemized bill will be provided for submission to your insurance carrier at the time of visit. However, it is your responsibility to submit the claim for reimbursement.

I understand that appointments must be cancelled at least 24 hours in advance or there may be a cancellation charge in the full amount of the appointment. I accept this cancellation policy and agree to be responsible for any charges due to a late cancellation.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Patient Signature (Parent if under 18)

For your convenience, we offer the following methods of payment.

CASH CHECK MASTER CARD VISA AMEX

I hereby authorize JILL T. SILVERMAN PH.D to keep my signature on file and charge my credit card for all services rendered. I understand that this authorization is valid until such time that I cancel the authorization through written notice to JILL T. SILVERMAN PH.D.

CARDHOLDER'S NAME: _____
CARD NUMBER: _____
EXPIRATION DATE: _____ CODE:_____

_____

Cardholder Signature (Parent if under 18)

_____

DATE

239 Glenville Road • Greenwich, CT 06831 • Ph: 203-532-1755 • Fax: 203-532-1518 • www.drjillsilverman.com