THE PSYCHOANALYTIC CLINIC
OF THE NEW JERSEY INSTITUTE

121 Cedar Lane Suite 3-A
Teaneck, NJ 07666

Clinic Payment Form

Please have patient make check payable to:

Psychoanalytic Clinic

Clinic Therapist:

Name: _____

Session
Date:_____

Patient Information:

First Name: _____

Last Name: _____

Number of sessions today: _____

Rate per session: _____

Room: _____

Time: _____

Amount of payment for today's session:

$_____ **check** _____ **cash** _____

(or) owes for today's session _____

Payments for prior visits (owed). Please list dates of prior sessions being paid for:

_____ _____ _____ _____

_____ _____ _____ _____

NOTE: A Clinic Payment Form must be submitted for each session ON THE DATE OF SERVICE (whether patient pays or owes). When patient pays for a prior session(s), please indicate date(s) above. Thank you.

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