Jason A Johnson, Psy.D.

Clinical Psychologist

1020 SW Taylor St., Suite 245
Portland, OR 97205

503-853-4998
jasonajohnsonpsyd@gmail.com
www.jasonajohnsonpsyd.com

Fee Agreement

I agree that payments or copays for services are due at the time of service and the responsibility for payment is mine. Denial of payment by an insurance carrier or other third party does not waive my responsibility to pay.

_____ Initials

I intent to pay in full for the session or co-payment at the time of services are rendered with check/cash/credit(debit) card. I will pay $_____ for the first session and $_____ for ongoing 45-50 minute sessions.

No Shows/Cancellation

I understand that no-shows or cancelled session will be charged to me at the full fee. I authorize Jason A. Johnson, PsyD, LLC to charge my credit card for any cancellation or no-show within the limits of the fee agreement above.

_____
Client Name

_____ _____
Client Signature Date

_____ _____
Jason A. Johnson, Psy.D. Date
Psychologist Resident