Patient Payment and Credit Card Agreement

All clients must submit a credit card to remain on file.

Payments may be made in check or cash; however a credit card on file is still required.
In providing us with your credit card information, you are giving our office permission to automatically charge your credit card on file for any/all of your payments due at time of visit. By signing this you authorize this agreement will remain in effect until discharged from therapy and all claims are paid. You may revoke this form at any time by submitting a written/oral request.

Co-pays, Co-insurance fees and Self Pay Session Fees*:* Due at time of the office visit. Missed payments will incur a $10 charge.

Outstanding Balance: (A) In the event your insurance has been terminated or a policy review resulted in denied claims, you will be responsible for the billed charges. (B) As noted in our attached cancellation policy, you will be charged a fee of $25 (first time cancellation) and full session fee (repeated cancellations) after a notice has been sent to advise you of the date of missed appointment.

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☐ **Visa** ☐ **MasterCard** ☐ **Discover** ☐ **AMEX**

Name Credit Card: _____

Billing Address: _____

_____

Email Address for Receipt:_____

Credit Card Number:___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Expiration Date: _____ Security Code: _____

Signature:_____ Date:_____