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Payment Agreement

This office requires that you have a credit card on file; however you have the option to pay by check or credit card. Please indicate your preferred method of payment:

_____ Check _____ Credit Card

- By completing and signing this Payment Agreement, you are indicating that you understand and agree to provide a valid credit card number, with expiration date, to have on file with this office.
- If your preferred method of payment is by check, payment is required either at each session or at the end of each month. If your payment is not received by the 10th of the month, for services provided in the prior month, your credit card on file will be charged the full outstanding balance.
- If your preferred method of payment is by credit card, your credit card will be charged on a monthly basis, by no later than the 10th of the month, following the month that services were rendered. Please note that we welcome Visa, MasterCard, or American Express.
- Any changes or cancellations must be made at least 24 hours in advance.
- For missed appointments or cancellations with less than 24 hours' notice, the full service fee will be charged.
- You (not your insurance company) are responsible for full payment of my fees.
- You will be provided with an itemized statement of your sessions and payments at the end of each month.

I understand and agree to comply with this Payment Agreement. I authorize the use of my credit card information for payment of services rendered.

*Client Name (Please Print):*_____

*Signature:*_____*Date:*_____

Please Indicate Type of Card: ____VISA ____MasterCard ____AMEX ____Discover

Card Number: _____

CVV:_____ Expiration Date: _____

Name (as it appears on card): _____

Card Billing Address: _____

Card Statement Zip:_____

Your credit card information will be held confidential, and this information will be secured in your client file.