COUNSELINGWORKS
ADOLESCENT · ADULT · COUPLES

Payment Policies and Procedures

Methods of Payment: (Please Select Your Preference)

_____ Check
_____ Cash
_____ Visa, MasterCard, Discover or AMEX

Insurance Co-Payment:

$_____ per visit

Cancellation/No Show Policy:

I agree that I will pay 100.00 for all missed appointment and appointments canceled without 24 hour notice. Initials: _____

Credit Card Authorization Request:

I authorize Counseling Works to charge my credit card for the following purposes: (When applicable)

_____ Co-payments
_____ Onetime payments on an account
_____ Any outstanding balances after date of service
_____ Charges for missed sessions or sessions which are canceled without 24-hour notice.

Name on Credit Card:_____

Type of Card: Discover Visa MasterCard

Card# _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Expiration Date: _ _/_ _

Security Code (last 3 #'s on back of card): __ __ __

I hereby give authorization for payment of insurance benefits to be made directly to Counseling Works, LTD for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I the event of default, I agree to pay a 30% collection fee and reasonable attorneys fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Client or Authorized Person's

Signature_____Date_____