Counseling and Development Inc.
8470 Holcomb Bridge Road – Suite 140
Alpharetta, GA 30022

CREDIT CARD PAYMENT RECORD

Client Name as it Appears on Card: ____

Card Number: ____________________________________ Expiration Date: ___________

Credit Card Billing Information: _________________ ___________ ___________

Street Number Zip Code Security Code

Security Code on Card (3 or 4 numeric digits): ___________________

Client Signature: ____

Signature indicates that you agree to allow your therapist to make charges on your card without you present.

Therapist's Name: ____

PLEASE READ AND SIGN

You are welcome to pay either using cash, check, or credit card. By filling out your credit card information you agree for your credit card information to be kept in your confidential file and used to pay for payments, co-pays, denied insurance claime, late cancellations and/or no-shows. Receipts and payment explanations will be available by request.

Counseling and Development Inc. is required by law to collect all co-pays at the time of service. There will be a $25.00 service charge for any unpaid/returned checks. Please note: we do not file secondary insurance unless required to do so by federal law.

If you have insurance that requires preauthorization, you must notify your clinician of any changes in your insurance coverage and benefits before each visit. It is your responsibility to ensure that your visits are fully authorized by your insurance company. By law, we cannot bill your insurance for missed appointments. You are responsible for the full payment of all appointments not cancelled with at least 24-hour notice.

I understand that I am fully responsible for my bill and will assume any charges not paid by my insurance company. I understand that I will be charged $100.00 for any appointments not kept unless at least a FULL 24-HOUR notice is given to the clinician.

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I consent for treatment necessary for the care of the above-named patient. I have read, understand, and agree to the office policies, attached.

______________________________ ________________

Signature of Patient or Guardian Date

____

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