Crosspointe Family Services - Payment Agreement

Patient/Guardian Information

Last Name: _____ First Name: _____ MI: _____

Responsible Party: _____ SSN: _____ Date of Birth: _____

Who does the client live with?: _____ Phone: _____

Payment Agreement

I, the undersigned client/parent/guardian, agree to pay for all services rendered and/or fees accrued to me or my ward immediately upon demand. I further agree that in the event of non-payment of any amounts due under this agreement I will pay interest thereon at the rate of 1.5% per month after 60 days of non-payment and will pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an outside agency for collections, I promise to pay an additional collection fee of 35% of the unpaid balance due.

Per the Informed Consent signed by me, failure to give 24 hours-notice for an appointment cancellation (no-show) will result in a $25.00 no-show/late cancellation fee that will be charged to my account or the credit card on file.

I understand that I am agreeing to the option of keeping a card on file. I agree and authorize Crosspointe Family Services to charge my credit card on file for payment(s) and/or Fee(s) due.
___at time of service
___Monthly/Biweekly/Weekly, beginning _____ and continuing on the same date/day unitl my balance is paid in full.
I agree to make all payments as agreed. If my circumstances change, I will notify Crosspointe Family Services as soon as possible. I understand that my account will be assigned to an outside collection agency after 90 days of non-payment and I will be responsible for all costs relating to the collection of my account.

___I have read and understand this agreement.

Credit Card Information

_____ Visa _____ MasterCard _____ Declined Amount _____

Card Number: _____ Exp. Date: _____

Security Code: _____ Zip Code: _____

Signature: _____ Date: _____

Witness: _____ Date: _____