Financial Policy

All payments are due prior to being seen. It is the policy of **Gilbert Counselors, LLC** to obtain and maintain on record a valid Visa or MasterCard and authorized signature. This will remain in your confidential file as a guarantee of payment and allows us to avoid having to take collection actions against any client.

The signed credit card collection policy is for services at the office of **Gilbert Counselors, LLC**. By signing below, you hereby authorize me to collect any outstanding amount, including co-pays, on your credit card listed below. **This includes missed appointment fees, which will be charged on the day of the missed/cancelled appointment when 24 hours' notice is not given.**

Client's Name:_____

Please circle one: Visa or MasterCard

Card Member Name:_____

Card Number:_____**CVU#**_____

Expiration Date:_____

ZIP CODE:_____

Card Member Signature:_____

Email address:_____

Telephone Number:_____

Date:_____

Provider:_____