Laura Durant, LMHC, Inc

Phone (561) 271-8129 Fax (561) 430-3862

FINANCIAL AGREEMENT

Patient Information:

Name: _____

Address:_____

City/State/Zip: _____

Phone/Cell: _____

Email: _____

DOB: _____ Social Security #:_____

Referring Agency: _____

Guarantor Information:

Name:_____

Address: _____

City/State/Zip:_____

Phone/Cell: _____

Email:_____

Payment Options

Payments may be made by cash, check, or credit card.
In order to make credit card payment the following information much be completed and a copy of the front and back of the card must be attached.

Credit Card #: _____

Card Holder's Name: _____

Expiration Date: _____

SVC#:_____ (last 3 digits in the signature panel on back, or 4 digits on the front of card)

Card Holder's address that credit card statement is mailed to:

_____

_____

Phone # _____

I am completing the credit card information of this form and do herby authorize Laura Durant, LMHC to charge my cardio card for services rendered at the time of the appointment and upon discharge for any outstanding balances. I hereby waive all protest to the credit card companies arising out of such automatic charging by my therapist. This authorization by me for Laura Durant, LMHC to charge my credit card after each service Has been rendered shall remain in effect until I notify Laura Durant, LMHC in writing, via certified mail, overnight delivery by FEDEX, UPS, or DHL, or email with email reply from Laura Durant, LMHC, that I wish to end this automatic charging agreement and with sufficient notice (generally at least 30 days), such that Laura Durant, LMHC, has a reasonable amount of time to act on this request. My monthly credit card statement will serve as my receipt.
I understand that I will be charged for missed appointments or late cancellations (less than 24-Hour Notice).

X_____
Patient or Guarantor Signature (if other than patient) Date