Payment Agreement Form

Patient Name: ______________________________________ Date: _______________________________

Client Number: _____________________________________ Balance on account: __________________

This agreement indicates that you agree to the following payment plan:

By signing this form I agree to pay ___________ monthly and understand that I am still responsible for any balance that occurs after this agreement. Payments will always be applied to the oldest date of service, unless otherwise specified by me.

<u>Please initial the following statement that applies to your method of payment</u>

______ I agree to make the payment above on my own. I understand that missing a payment may affect future services or result in being sent to collections

______ I agree to make payment with the credit card on file ending _________ to be charged to my card the first week of each month unless otherwise indicated

Exception – Day of each month to be billed: ____________________ (Example: 15th of each month)

______ The agreed amount will be charged to the credit card below the first week of each month unless otherwise indicated

Exception – Day of each month to be billed: ____________________ (Example: 15th of each month)

Credit card information			
❑ Amex ❑ Visa ❑ Mastercard ❑ Discover	Credit Card #		
	Expiration: _____/_____		CCV:
	Cardholder's Name:		

Card Holder Address: ____

City_______________________ State _______ Zip___________

Phone Number: (____) ______ - ______

Cardholder Signature: __________________________________ Date: ____/____/______

It is your responsibility to notify our Billing Office immediately if there are any changes to your address or credit card.

___________________________________ ____

Patient Name (Please Print) Patient Signature Date

___________________________________ ____

Office Staff (Please Print) Office Staff Signature Date

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Revised 8/24/2022