

**Deborah Owens, LPC, 8506 Germantown Ave., Philadelphia, PA, 215-802-6521**

By signing this agreement, I am authorizing Deborah Owens, LPC to bill my credit card for all professional services rendered to the "Client" that are not paid at the time of service, or for situations which fall under the late cancellation policy listed below. I agree that I will not dispute those charges, which may include, but are not limited to:

- A missed session fee of \$70. if the client does not show for an appointment and has not cancelled or rescheduled with 24 hrs. notice, as outlined in the cancellation policy
- Telephone contact in excess of that usually associated with services, prorated at my regular hourly rate, with prior notice given before any charges are incurred, this may include phone contact in excess of 15 min. or completing disability or other forms
- Deductibles, excluded services, insurance payments made to someone other than the provider, or other charges that have not been directly reimbursed by insurance
- Checks that are returned will incur the check amount and an additional \$18. fee

If you have questions or concerns regarding any part of this fee structure or billing/payment policies, please discuss these with me as soon as possible. **This form will be securely stored in client's clinical file and updated upon request at any time.**

Credit Card Type (check one):  Visa  MasterCard

Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Name as Printed on Card: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_

Signature of Payor: \_\_\_\_\_

Print Name of Payor: \_\_\_\_\_ Date: \_\_\_\_\_

**Please Initial each of the following *except the first sentence unless it applies*:**

\_\_\_\_ Recurring charges for services in the amount of \$135. per visit. (140. for couples) I may opt out at any appointment by choosing to use cash or a check instead of credit/debit card.

\_\_\_\_ \$ 70.fee for cancellations with less than 24 hours notice and for appointments I miss without notice which will be billed to my card for this purpose.

\_\_\_\_ I understand my card will be charged for returned checks for amount of check plus \$18.fee

\_\_\_\_ Balances of charges not paid within 7 days of service, or not paid by insurance, will be charged on credit card or deposit check.

\_\_\_\_ I will not dispute charges for sessions I have received, appointments I have missed with less than 24 hrs. notice, or charges due to returned checks.

\_\_\_\_\_ (signature)

\_\_\_\_\_ (date)