256 Beacon Ridge Blvd.
Chapel Hill, NC 27516

Automatic Credit Card Payment Agreement

Please charge this credit card automatically for services provided.

Name of Client:_____

Name of Credit Card (if different):_____

Credit Card #:_____

Credit Card Type:_____ Expiration Date:_____ Code:_____

Missed Visit Fee (Charged on the date of the scheduled visit for no-shows or cancellations made with less than 24 hours notice): $145

All services will be charged at the time of service or shortly thereafter, according to the fees established in the Professional Service Agreement.

Clients are responsible for providing current and valid credit card information on this form and for updating this information in the case that changes to the preferred payment method need to be made. In the case that a charge is denied, the client will be responsible for providing and alternate payment method (e.g., valid credit card, cash or check) within 7 business days of the denied charge.

Services will not be continued if fees are not paid in a timely manner. Delinquency of 30 days may result in termination of treatment. Additionally, accounts that have no payments for over 90 days may be sent to an outside collection agency.

Client or Guardian Signature:_____ Date:_____

Cardholder Signature:_____ Date:_____
(if different)

Clinician Signature:_____ Date:_____