Austin Counseling Specialists LLC
www.atxcounselors.com
512-814-6027

PATIENT PAYMENT CONSENT FORM

Patient Name: ____

Name on Card if Different: ____

Card Number: _________ -- __________ -- __________ -- __________

Exp. Date _______ Security Code: ________

Card Holder's Billing Address for Monthly Card Statements:

____

Street City/State Zip Code

I authorize Austin Counseling Specialists LLC to charge my card for professional services as follows:

______ Initial session in the amount of __________

______ Recurring Charges in the amount of ___________

Check One:
_____ monthly (on what date: _____________)
_____ weekly
_____ per session

By signing this form, you also agree that you will be charged automatically for any no-show or cancellation less than 24 hours in advance in the amount of $70.00.

Please be aware that unless an agreement is negotiated with the therapist (or representative) all outstanding balances not paid within 30 days after a bill is sent, or the insurance company has notified you or this office of your balance, will be charged to your credit card.

Card Holder's Signature: ________________________________Date:____________

Please note that all information will be kept confidential and that information will only be used to obtain payment for services.