



Arrowhead
Family
Systems, LLC

PAYMENT AGREEMENT

If using HSA, FSA, or Credit Card for payment

Name on Credit Card _____

Card Number _____

Expiration Date _____ Security code _____ Billing Zip _____

Email for send of Receipt _____

I authorize:

- Assessment or Consultation fee _____
- On going copay, session, or group session payment _____
- Administrative fee to be applied to first group session \$20.00
- Scheduled dates to settle an unpaid balance

I agree to allow Arrowhead Family Systems, LLC to charge the above credit card to be used to settle fees for therapeutic services.

Signature of person authorizing use of credit card

Date
