Arrowhead
Family
Systems, LLC

PAYMENT AGREEMENT

If using HSA, FSA, or Credit Card for payment

Name on Credit Card_____

Card Number_____

3 digit security code _____ Expiration Date_____

Billing Zip Code of Credit Card _____

Email for send of Receipt _____

I, _____, authorize 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

_____ _____