PAYMENT AGREEMENT

If using HSA, FSA, or Credit Card for payment

Name on Credit Card_____

Card Number_____

Expiration Date _____ Security code _____ Billing Zip _____

Receipt □No □Yes - Email address: _____

I authorize:

- □ Assessment or Consultation fee _____
- □ Therapy _____
- □ Group therapy _____
- □ 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

_____ _____