Arrowhead Family Systems, LLC

PAYMENT AGREEMENT

If using HSA, FSA, or Credit Card for payment

For services with Anissa Hamlin, MFT Intern

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:

- ☐ Assessment or Consultation fee _____
- ☐ On going copay or session fee payment _____

I, _____, agree to allow Anissa Hamlin, MFT Intern, or supervisor Dr. Kimberly Bailey, DBH. LMFT, to charge the above credit card to be used to settle fees for therapeutic services.

Signature of person authorizing use of credit card Date

_____ _____