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:

- ☐ 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 Rachel White, MA LAMFT, to charge the above credit card to be used to settle fees for therapeutic services.

Signature of person authorizing use of credit card Date

_____ _____