PAYMENT AGREEMENT

If using HSA, FSA, or Credit Card for payment

Patient Name _____

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

  _____
- □ Rate Change _____ Reason _____

  Effective Until _____

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

I acknowledge that I will receive a Text to Pay message should I have a past due balance. This is a HIPPA compliant and encrypted service.

Signature of person authorizing use of credit card Date

_____ _____