☐ **Private Insurance Clients:**

I authorize CAV Family Therapy, Inc to bill my private insurance plan with: _______________

I am responsible to pay fees for each session in accordance with the patient responsibility listed on the Explanation of Benefits, which is issued by my private insurance carrier. If my insurance carrier denies the claim, I am financially responsible for the billed amount.

☐ **Cash Pay Clients:**

I agree that I am responsible for the payment of:

$_________ per session

*which is due and payable at the time of the session. If the session extends more than 15 minutes, and additional cost of **$_________** will be charged.*

Please check one: ☐ Accept a copy of Agreement ☐ Decline a copy of Agreement

Credit Card Authorization

All clients are required to keep a valid credit card on file.

For Insurance clients this credit card will **only** be used as a form of payment for fees incurred for deductibles, co-payments, co-insurance, no-show or late cancellations, or returned checks.

Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Card Number: ______________________________ Exp. Date: _____________ CVV Code: _________

Name as Printed on Card: ____

Billing Address: ____
(Street and Number, City, State, Zip)

I agree that all the information provided is accurate and complete. With my signature, I certify that I am an authorized signer on the above credit card account. I authorize CAV Family Therapy, Inc. to make charges to my credit card for services rendered according to the terms specified in this Contract.

______________________________ ______________________

Authorized Cardholder Signature Date

____

Print Client Name

______________________________ ______________________

Signature of Person Financially Responsible Date