Family Guidance Centers

Self Pay Patient Contract

Form Completion Date _____

The patient, _____, agrees to pay $_____ per session for all visits with the therapist, _____ at Family Guidance Centers. This is a self pay agreement and legally binding document that makes the patient liable for all session billings. This means that an insurance company will not be billed. **The patient is held responsible for paying their full balance at each appointment.**

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Therapist Signature	Printed Name	Date

Credit/Debit Card Payment Authorization

I authorize Family Guidance Centers to initiate recurring charges to my Credit/Debit Card listed below for the total amount due at each session for the agreed upon cost above.

If necessary, I authorize Family Guidance Centers to initiate adjustment for any transactions credited or debited in error. This authority will remain in effect until Family Guidance Centers has received written notification from myself to cancel it, allowing 30 days for action on my cancellation notice.

Patient Name: _____ Patient DOB: _____ /_____ /_____

Parent/Guardian Name: _____ Parent DOB: _____ /_____ /_____

Phone Number: _____ Email: _____

_____ _____

Signature Date

Credit Card Information
Card Type: ☐ Visa ☐ Mastercard ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____/_____
CVV2 (3 digit number on back of card): _____
Cardholder ZIP Code (from credit card billing address): _____

_____ _____

Cardholder Signature Date