Family Guidance Centers

Payment Plan Patient Contract

Form Completion Date _____

The patient, _____, agrees to pay $_____ every **week/bi-weekly/month (circle one)** for the balance due for sessions with the therapist, _____, at Family Guidance Centers. This is a payment plan agreement and legally binding document that holds the patient liable for the entire balance due. **The patient is held responsible for paying their full agreed upon amount at the payment interval promised.** If your provided payment method declines three times in a row, this payment plan will be rescinded and we will proceed with our usual collection procedure. You will be notified each time your payment method declines.

_____	_____	_____
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 the frequency and rate listed 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