CORAL GABLES Counseling CENTER

FINANCIAL AGREEMENT

I, _____ agree that the responsibility for the hourly charge of $ _____ and/or a co-payment of $ _____ at the Coral Gables Counseling Center is mine (Initial visit $ _____.)

I agree to assign to the Coral Gables Counseling Center any insurance benefits available to me. However, should said insurance not provide for the expected coverage, I am fully responsible for the full agreed upon fee. I also understand that if I have not paid my balance within 60 days, Coral Gables Counseling Center will turn my account over to an outside collection agency without further notice. I agree to be responsible for any additional collection fees that may occur in this event.

I understand and have discussed the above conditions. I am willing to accept treatment under these conditions.

Patient Name: _____

X _____ _____ _____

Patient or Parent/Guardian | Patient or Parent/Guardian Name | Date

CREDIT CARD AUTHORIZATION

In an effort to avoid difficulties with your account, please provide credit card information on the space below. This information will only be used in processing payments due to one or more of the following: co-payment/hourly balance, returned bank checks, other declined credit cards, missed or late cancelled appointments ($ _____ each), denial of expected coverage by insurance companies, and phone/Skype sessions.

Please rest assured that we will make every effort to discuss your account before using this avenue to bring you balance up to date. Thank you for your cooperation.

CREDIT CARD TYPE ☐MASTERCARD ☐VISA ☐AMEX ☐DISCOVER

CARD NUMBER ___ ___ ___ ___ - ___ ___ ___ ___- ___ ___ ___ ___ - ___ ___ ___ ___

EXP. DATE: _____ / _____ CVV: _____ ZIP: _____

I agree to let Coral Gables Counseling Center charge my credit card above after each session for the amount of $ _____ per hour (Initial Visit:$_____) until this authorization expires on_____.

(Auth. exp. for Amex only)

X _____ _____

Cardholder Signature | Cardholder Name