Credit Card on File Agreement



The Arlington Center The Arlington Center for Attention Deficit Disorders

& Arlington Counseling Associates 847-577-4530

A GROUP PRIVATE PRACTICE OF COUNSELING & PSYCHOLOGY

CREDIT CARD ON FILE AGREEMENT

Please be advised of the following terms of our Financial Policy Agreement:

Outstanding Bills: It is not our policy to carry balances with our clients. Co-Pays are due at the time of service. Unless there is a financial hardship approved by The Arlington Center, we will charge unpaid co-pays and/or charge deductible/co-insurance after Insurance has processed the claim or at month end.

Missed Sessions: Any missed sessions or cancellations without a 24-hour notice will be charged to your designated credit card.

| Therapist's Name _ | Client Name: | |
|--|--|--|
| Credit Card Type: | [_] VISA [_] MasterCard [_] Discover Cardholder | |
| Cardholder's Name: | | |
| Billing Address: | | |
| | | |
| Credit Card Number | : Expiration Date: | |
| Security Code: | Billing Zip Code: | |
| I agree to the terma any missed appoint | s above and authorize The Arlington Center to bill my credit card for any unpaid balances due or for ments. | |
| Signature: | Date: | |
| | | |
| The | Arlington Center 3375 North Arlington Heights Road / Suite F / Arlington Heights, IL 60004 | |
| | | |