## 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 terms above and authorize The Arlington Center to bill my credit card for any unpaid balances due or for any missed appointments.

Signature: _____ Date: _____