



We do our best to provide quality services to our clients. In order to preserve that mutually trusting and respectful relationship, the client needs to assure that payment for services is made in a timely manner.

PLEASE READ CAREFULLY

Standard insurance co-payments are required at the time of service.

There is a \$25 fee for returned checks. There is a \$55 fee for late cancellations (less than 24 hours notice) and a \$75 fee for no show appointments. Payment of these fees will be due upon receipt of a bill and is not billable to your insurance.

To secure payment for our services, we require that your credit card information be kept on file for uncovered expenses or fees due to missed appointments with less than 24 hours notice.

We will file with your insurance company. However, if we have not received payment within 90 days, it becomes your responsibility and we will charge the balance to your credit card.

I _____, have read and understand the
(Print Name)

above and agree to the terms and conditions as stated. Furthermore, I authorize Counseling Associates of Southern Illinois to charge my credit card for any of the aforementioned fees, services not covered by insurance, or charges that are in excess of what my insurance covers (e.g. co-pays) if applicable. All balances are due at the time services are rendered. If the balance of your bill is in excess of \$100 by the end of 3 months, we will charge your credit card. **You will be contacted by us prior to charging your credit card.**

Credit Card: Visa Mastercard Discover

Credit Card # _____ Expiration Date _____

CVV (3 or 4 digit code) _____ Zip Code _____

Signature _____ Date _____