

Payment Agreement Form

Payment for services is due no later than 30 days from receipt of your bill from me. Because it is the least likely method of interception, I typically send invoices out by US Mail at the end of each month. You will be expected to pay the monthly balance within 30 days upon receipt of my bill, unless we agree otherwise. You may send a check to me or bring in a credit/debit or HSA card to my office to charge. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, interest will accrue at the rate of 1.5%/month, at which point I may use legal means to secure payment.

In the event that I experience an event that results in a Late Cancellation/No-Show, or if my payment lapses beyond 30 days, I give Pamala Roskelley LCMHC PC to charge my credit card for the associated fee. My credit card information is as follows:

Email Address:

Card Type: (Visa, MasterCard, Discover, American Express or HAS):

Card #: _____ Expiration: _____

Security Code: _____ Zip Code associated with card: _____

My Signature below shows that I understand and agree to adhere to the Late Cancellation or Past Due Payment Policy. I also agree to the charge of my credit card provided for fees associated with this policy.

How do you prefer to take care of session charges?

I will bring in or mail a check.

I would like to use the following HSA or debit/credit card entered above

I AGREE TO THE TERMS OF THIS AGREEMENT AND ACKNOWLEDGE THAT I HAVE RECEIVED THE HIPAA NOTICE OF PRIVACY PRACTICES AND A CLIENT COMPLAINT FORM

Signed (Client) _____ Date _____

