535 E. 4500 S. Suite D280 Salt Lake City, UT 84107
Chat & Change Phone: 801-699-3133 or 385-368-8228 Fax# 801-747-6858

Payment Agreement

THIS FORM MUST BE FILLED OUT COMPLETELY FOR EACH INDIVIDUAL BEING SEEN

RESPONSIBLE PARTY NAME	CLIENT NAME (IF DIFFERENT)		
STREET	**CITY**	**STATE**	**ZIP**

CREDIT CARD:	It is our policy to keep a credit card on file to secure payment for services. The credit care number is stored in a HIPPA compliant encrypted Electronic Medical Record. Your card will be charged for session fees, co-payments, co-insurance, and late appointment cancellation fees. We charge $130.00 for appointments that are cancelled with less than 24 hours notice. We will send you a statement before charging a balance due that is beyond your co-pay or applicable cancellation fees. If you absolutely do not want to use a credit card we require a $ 130.00 refundable retainer. you must also agree to pay your session fee/copay in cash or check at each session.

CREDIT CARD NUMBER (REQUIRED)	EXPIRATION DATE	Security Code (on back)
Name on Card	**Billing Address (if different than above)**	
Card Holders Signature	**Date**	

Session Fee: While we submit claims to your insurance company, there is no guarantee that they will cover your sessions. If your insurance company does not pay after 45 days, you will be billed for the balance.

☐ **PRIVATE PAY: I, AGREE TO PAY $_____ AT EACH VISIT.**

☐ **INSURANCE CO-PAY/CO-INSURANCE**: I have verified with my insurance company that my co-pay/co-insurance amount I $ _____ at each visit. (Please Note that the information for mental health copay/coinsurance is not usually available on the insurance card. Please call your insurance company to verify your mental health benefits if you are unsure.)

☐ **INSURANCE DEDUCTIBLE**: I am using insurance and I have a deductible of $ _____. My insurance calendar year starts in _____. I understand that I have to pay the session fee of $ _____until my deductible is met, when applicable. (Please note that not all insurances have the same start date for their deductible cycle, and not all start at the beginning of the calendar year. Please call your insurance company to verify when your deductible is applicable)

☐ **INSURANCE BENEFITS UNKNOWN**: I've decided to throw caution to the wind, **I HAVE NOT VERIFIED** my benefits. I understand that it is my responsibility to know what my insurance will cover and that I will be billed for any balance due if my insurance does not cover my sessions.

THIS SECTION MUST BE FILLED OUT IN FULL EVEN IF CARD IS ATTACHED

Primary Insurance Company	Secondary Insurance Company
Member ID _____ Group # _____	Member ID _____ Group # _____
Subscriber's Name (Insured's Name)	Subscriber's Name (Insured's Name)
Subscribers Date of Birth **Relationship to Client**	**Subscribers Date of Birth** **Relationship to Client**