



4525 HARDING ROAD, SUITE 227, NASHVILLE, TN 37205
o. 615-812-4526 | f. 615-933-6622
likeyoucounseling@gmail.com
www.likeyoucounselingservices.com

PATIENT PAYMENT AGREEMENT

Patient Information:

Last Name : _____ First Name : _____ Middle : _____

Payment Agreement

Payment is expected at the time of service. Payment may be made by cash, check or credit card. Any balances will be due upon receipt of the monthly statement. Accounts over 30 days are subject to a late fee.

To save an appointment time, credit card information will be required. In the event you do not come to your appointment and do not provide at least 48 hours notice, the full appointment fee will be charged to your credit card. If you cannot come to your appointment, please call to cancel or reschedule as soon as possible. At the time of your appointment, you may choose another payment method if you do not wish your credit card to be charged.

Appointment Overages

Any appointment that goes over the allotted 60/90/120 minute appointment time is subject to additional fees. These fees will be calculated in 15 minute increments at the cost of \$30 per 15 minutes. These fees will begin 5 minutes after the scheduled end time of clients appointment.

Guarantor Information (Complete only if the patient is NOT the responsible party):

Name of responsible party : _____

Address : _____

City : _____ State : _____ Zip : _____

Contact Phone #: _____

Date of Birth : ____ \ ____ \ ____

Social Security Number: _____

Guarantor-Financial Responsibility Agreement:

I, the undersigned, regardless of any insurance coverage, am financially responsible for all charges generated for this patient. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days may be subject to a late fee. I understand that unpaid balances over 90 days past due may be referred to a collection agency.

Signature of Cardholder: _____ Date: _____

Credit/Debit Card Payment for Professional Services

_____ VISA _____ MasterCard _____ Discover _____ American Express

Name as it appears on Card: _____ Billing Zip Code _____



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Credit/Debit Card # _____ Exp. Date _____

Card Security Code # _____ (Located on back of credit card 3 or 4 digit number)

I/We authorize LIKE YOU COUNSELING SERVICES to bill the above credit/debit card for professional services at the time of service provided for _____ (patient name). I will notify LIKE YOU COUNSELING SERVICES in writing if I no longer want my credit/debit card billed.

Signature of Cardholder: _____ Date: _____

Credit/Debit Card Payment for missed or cancelled appointments:

I authorize LIKE YOU COUNSELING SERVICES to charge the above credit/debit card when _____

(patient name) does not give advance notice for a late-cancellation or no show, as per the policies. I understand that if I do not want my credit card billed for this purpose I am still responsible for these fees and will be billed accordingly.

Signature of Cardholder: _____ Date: _____