Coastal Psychology & Education Associates, LLC

32828 Reba Road, Suite A

Millville, DE 19967

Date:

Credit Card Number:

CID: Expiration Date:

Dear Patient

Your insurance company will be billed for your outpatient psychotherapy sessions.

By signing this form your agree that any remaining balance due as the patient's responsibility will be charged to your credit card.

You will receive a follow up letter reflecting the charges applied to your credit card. I certify that this is my credit card and I am legally authorized to give permission for its use.

I agree to pay the amount so charged. In the event that there are any problems with my credit card payment, I agree to pay all collection costs and reasonable attorney fees incurred in attempting to collect on the account balance.

Signature_____ Date_____

Printed Name_____

Witness_____