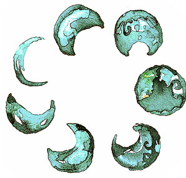

Many Moons Psychotherapy Services, Inc.
an arts-based approach to emotional health
4 Cottage Street
Freeport, Maine 04032
office: 207-504-2664
www.manymoonstherapy.org

Card "On- File" Payment Policy

Client:

Parent/Guardian:

1st Card Number: ____________________________________ Is this an HSA card? _______

Expiration Date: ____/____

CVV Code: __ __ __

Billing zip code: __ __ __ __ __

2nd Card Number: ____________________________________ date provided: _______

Parent/Guardian:

Expiration Date: ____/____

CVV Code: __ __ __

Billing zip code: __ __ __ __ __

Card Payment Agreement: All credit/debit/HSA card payments are charged remotely, after services have been rendered. I understand that my card may be charged anytime from immediately after a service until the expiration of my card. I am legally authorized person to use this card to pay for services.

General Financial Agreement: I understand that I am financially responsible for services not covered by my insurance, including a $70.00 fee for any missed appointments if I have not notified my provider in at least 24 hours in advance. I understand that I will be charged a late fee for unpaid co-pays/bills after 30 days. I understand that I will be billed for any consultation services between my provider and anyone I signed a release for her to speak with. I understand and authorize charges due to consultation with other providers, school personnel, and legal parties. These charges are not covered by my insurance benefits.

Client Signature:_____________________________________ Date:_________

Parent/Guardian Signature:____________________________ Date:_________

Parent/Guardian Signature:____________________________ Date:_________

Clinician Signature:__________________________________ Date:_________